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HISTORY OF TREATMENT OF MENTAL DISORDERS

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The history of the scientific discipline known as psychiatry begins in areas that have little in common with modern psychology. Its roots lie in the murky practices of ancient wizards and shamans, of priest-physicians and mythological gods, of exorcisers and sages. That which eventually came to be included in the domain of psychiatry belonged at one time to magic and witchcraft, ancient medicine, and *materia medica*. Neither psychiatry nor psychotherapy evolved from a sophisticated background; religion, supernaturalism, mythology, philosophy, astrology were among their progenitors.

Yet, although the roots of psychiatry must be tracked into many obscure corners of man's preoccupations, ancient medical records show that the main outlines of psychiatry as it is known today became discernible in early Greek civilization. While amulets and incantations were used to combat mental disease in ancient days, Hippocrates, the Father of Medicine (460?-377 B.C.), described mental disease in naturalistic terms. In *Corpus Hippocraticum*, he stated that epilepsy, until then considered due to demoniacal possession,

. . . appears to me to be nowise more divine nor more sacred than other disease, but has a natural cause from which it originates like other affections.

The shedding of the aura of mysticism that hung over mental illnesses was a lengthy and tortuous process. Indeed, even Plato (427?-347 B.C.) indicated that mental disorders were, to his mind, partly somatic, partly moral, and partly divine in origin. On the whole, however, Greek medicine, which strongly influenced the Romans and eventually all of Europe, established the fact that the treatment of insanity was within the realm of medicine. Celsus, whose treatise, *De Medicina*, became a standard text for centuries, clearly stated the medical position of the time (about A.D. 25) when he wrote:

I shall begin with insanity, and first that form of it which is both acute and found in fever. The Greeks call it phrenesis . . .

Galen, in the second century, championed the "rational" system of medicine, which had been derived from Hippocrates. Striving to understand the relation of disordered brain tissue and mental conditions, Galen linked disturbance of the "four humors" (blood, phlegm, yellow bile, black bile) as they coursed within the body with melancholia, depression, and delirium. Galen concerned himself with the mind (soul or spirit) as it was affected by disordered physiology (excess or deficiency of humors); thus excess of humors caused one disease, while deficiency caused another. Galen experimented with spinal cords of monkeys, studied feeble-mindedness and dementia, laying the foundation for a naturalistic view of insanity. Before the decline of classic science during the Dark Ages, Galen's writings constituted, in Gregory Zilboorg's words, ". . . a kind of summary of, as well as epilogue to, the classic Greco-Roman period in medicine."

Over the centuries of this era, the evolution of psychiatry can be traced through the semantic changes in terms designating mental disease. "Frenzy," "lunacy," "madness," "insanity," "neurosis and psychosis" were symbols of the successive steps through which psychiatry gained maturity. Except for a few pioneering and farsighted men, it was not until a century and a half ago that mental disturbances, now dignified as psychiatric in origin, were recognized as lying in the domain of medicine.

It should be noted that with the fall of the Roman Empire, about the fifth century A.D., Arabic and Jewish medicine rose in prominence. Men like Avicenna (A.D. 980–1037) and Maimonides (A.D. 1135–1204), respected as teachers and writers, dealt sanely with insanity in opposition to the superstition and intense religiosity of Western Europe.

But, while the followers of Hippocrates struggled to explain the illnesses of the soul through the theory of bodily humors, and Muslim and Jewish physicians were treating patients with knowledge aforethought, many of Europe's "lunatics" were subjected to incantations, prayers, amulets, and exorcism. Mysticism was the therapy of the time, "sin" and demons the causes of madness, ritual and doggerel, the cures. That this unphilosophic attitude toward physical and mental troubles was well-nigh universal can be seen by comparing an Anglo-Saxon prescription for a "fiend or demoniac":

When a devil possessed the man or controls him from within the disease: a spew drink or emetic, lupin, bishopwort, henbane, corpleek: pound these together, add ale for a liquid, let it stand for a night, add fifty bibcorns of cathartic grains and holy water—to be drunk out of a church bell. . . .

with a Talmudic recommendation for “night blindness”:

. . . take a rope of hair, tie one end to the patient’s leg and the other to the leg of a dog. Then let children make a noise with a potsherd, exclaiming, “Old dog, foolish hen!” After that collect seven pieces of meat from seven houses, place them in the socket of the door and eat them upon the ash-heaps of the town. . . .

Though prevailing attitudes during the first half of the present millennium were heavily tintured by witchcraft and supernaturalism, voices were raised for the humanitarian treatment of “frenzied” patients. The monastic tradition of kindness and loving gentleness and the spiritual calm within sick houses of the Society of Hospitalers, extended to “madmen” as well as to fevered patients. The counsel of Bartholomaeus Anglicus, an English Franciscan friar, was couched in reasonable terms far removed from magic or demonology and carried a distinctly modern note. For melancholics, Bartholomaeus recommended:

. . . The medicine (treatment) of them is that they be bound that they hurt not themselves and other men and such patients must be refreshed and comforted and withdrawn from cause of any matter of busy thoughts and they must be gladdened with instruments of music and some deal be occupied. . . .

Many were cared for rationally and gently in sick houses and monasteries but, in the crosscurrents of medieval times, many other unfortunates, unrecognized as demented, hysterical, or feeble-minded individuals, were mishandled by inquisitors and pilloried by exorcists. Witchcraft turned the Christian ethic of patience, humility, and mercy into a weapon against those who were too ill to believe or rebellious of belief. During this period, witchcraft strove to explain hysterical and psychopathic symptoms in terms of demon possession. Such signs as the *Stigmata Diaboli*, “sometimes like a blew spot, or a little tate, or reid spots, like flea biting . . . in secret places, as the hair of the head, or eyebrows, under the armpits . . .” were accounted of diagnostic significance in cases of possession:

If he feigns to be mad, and the strength of his body grow and augment,
If he becomes dumb, deaf, insane, blind . . .

If the disease is such that the doctors cannot discover or diagnose it. . . .

Witchcraft and witch-hunting became a medicolegal test, a diagnostic science, and unwittingly, a form of psychotherapy.

With the Renaissance, demonology as a medical and psychological method faded slowly. The "possessed" were treated by medical men; such men as Johann Weyer, whom Zilboorg calls the "first psychiatrist," as early as 1579 decried demon possession as the cause of hysteria and other mental illnesses. Robert Burton, cleric turned psychiatrist, cynically signaled the slow transformation of the seventeenth century when he wrote:

'Tis a common practice of some men to go first to a witch, then to a physician; if one cannot, the other shall; if they cannot bend Heaven, they will try Hell.

During the eighteenth century, clinical medicine aspired to the level of a science; diseases were grouped into ten classes and 295 genera. Psychology grew to man's estate with Thomas Hobbes's associationism and Étienne Condillac's physiology of sensation. Neurology attained stature with Johann Reil's anatomical studies (1796), and a galaxy of brilliant innovators and discoverers laid the groundwork for the mental sciences.

In revolutionary France (1793) Philippe Pinel struck the chains from the manacled madmen in Paris' Bicêtre Hospital. In so doing, he symbolically established psychiatry as a clinical field and humanitarianism as a psychotherapeutic approach. The effect of Pinel's teaching and work, along with that of the Tuke family in England, was quite promptly reflected in improvements in asylum care. The "moral treatment," as it was then called, replaced the purges, bleedings, restraints, and rigid confinement of the insane. Although there were many indignities and horrors to be combated behind the gray walls of the asylum, a spirit of hopefulness was evident.

A hurried glimpse of the panorama of treatment in the nineteenth century, as reflected in reports on asylums of that period, would reveal the larger, airier buildings; the trend to replace "padded iron collars . . . belts with manacles . . . the quarterboots of Dr. Charlesworth . . ." with "methods that directly agitate the intelligence and emotions

of the insane . . ."; the change from the designation of "asylum" to that of "hospital."

Gradually also, clinical confusion decreased: dementia, catatonia, hysteria, melancholia, and general paralysis, were being slowly conceptualized not as bizarre symptoms that might well be wafted down from the moon but as results of nervous system infection, of the pressure of emotional strain, of disobedience to the laws of hygiene, of "neurasthenic reactions" (reactions to weakness or exhaustion of the nervous system), and of distortions of the "life history" of the patient. Psychiatry as a clinical discipline was firmly entrenched: the loose ends of lunacy were gathered up and deposited into the hands of physicians.

Scientific psychiatry received further backing from the work of neuropathologists and advances in treatment of nervous system syphilis. At the turn of the century, Franz Nissl was able to say: "As soon as we agree to see in all mental derangements the clinical expression of definite disease processes in the cortex, we remove the obstacle which makes impossible agreement among alienists."

Therapy, on the other hand, was not quite so well organized, nor could it be so didactically circumscribed. Hypnosis under the aegis of Jean Martin Charcot had attained scientific respectability if not exactitude. Suggestion, in the hands of A. A. Liebeault and Hippolyte Bernheim, simplified treatment by hypnosis and persuasion. The rest cure of Silas Weir Mitchell and electrical stimulation were successfully used with hysterics and neurasthenics. But a cogent meaning of these successes, a dynamic psychotherapy, awaited the touch of Sigmund Freud, who struggled alone over the years to understand psychic dissociation and the influence of the unconscious "mind" on nervous symptoms.

The development of psychoanalysis from Freud's "method of analysis" is often taken as a starting point for modern psychotherapy. It has stimulated, enlivened, and deepened psychotherapy, probably for all time. For the present purpose, only the high spots in the history of analysis will be dealt with.

For the first two decades of this century, psychoanalytic concepts were tested in practice on neurotic patients. By the end of World War I, the importance of the unconscious "mind" in forming symptoms was acknowledged. Shell-shock cases left as an aftermath of war, the great importance of infantile rejection and deprivation, the importance of psychosexual factors, the significance of symbolism in human thinking and neurosis, all revolutionized psychotherapy. It also intensified psychotherapy by an awareness of the transference (and later the counter-

transference), and the defensive meaning, of symptoms. Thus, psychoanalysis infiltrated into psychiatry to enrich its body of theoretical knowledge and to give meaning to depth psychotherapy.

Actual psychoanalytic technique during the decades from 1925 to 1945 arose basically from Freud's researches and evolved from his metapsychology. The essential aims of therapy were the uncovering of unconscious drives and feelings, analysis of the transference, mobilization of the energies of the id, reduction of severity of the superego, and aiding the ego to regain its executive control power. Many people were instrumental in developing this technique: such names as Sandor Ferenczi, Karl Abraham, Edward Glover, Paul Federn, Ernest Jones, A. A. Brill, Anna Freud, and many others, are among this group. By the 1940's, psychoanalytic practice was standardized to the degree that such a complicated and individualistic treatment would allow.

In the meantime, a subtle shift in accent to the social factors in causality of neurosis became evident. Here Alfred Adler, Karen Horney, Abram Kardiner, Harry Stack Sullivan, and Paul Schilder, gradually introduced the view that social pressures and social relationships were as significant as repressed individual instinctual drives in the causing of neuroses. The chief result of these modifications (and here Carl Jung's accent on the Collective Unconscious was a remote but still active factor) was to be found during the 1940's in technical modifications of the treatment process. Less passivity on the part of the therapist, greater flexibility, and "brief" therapy that emphasized "corrective emotional experience" was adopted. The number of hours was reduced, the couch was abandoned in part, less attention was paid to analyzing the earliest psychological experiences of the patient.

Coincidentally, during the 1940's and 1950's, a gradual diffusion of analytic principle passed to all types of psychotherapy, even to counseling and some areas of group therapy. While the number of "hard core" psychoanalysts increased slowly, the number of psychotherapists and the influence of psychoanalytic treatment principles expanded enormously in the decades from 1941 to 1961; "dynamic" psychotherapy became the hallmark of modern psychiatric practice.

Of the newer approaches to psychotherapy, one that has recently been growing in popularity is group therapy. Within a decade of its introduction into psychiatric practice, several types of group therapy were distinguishable: activity group therapy, analytical group therapy, psychodrama, nondirective or client-centered group method, the eclectic group therapy, and instructional or inspirational group work.

A brief description of these types of group therapy illustrates the wide and rapid spread of such work. In the 1930's, S. R. Slavson developed activity group therapy. Here, children involved in delinquency, sociopathic behavior, and neurotic "acting out" were treated in an atmosphere of permissiveness. Following Slavson's early work, Paul Schilder and Louis Wender gave psychoanalytic form to group therapy. By 1945, group therapists freely utilized factors familiar from psychoanalytic treatment of individual patients.

From 1950 on, many workers have added variations in analytic group practice: co-therapists have been utilized; dream material has been analyzed; the "here and now" have been emphasized; unconscious representations of infantile life have been worked with; analytic group therapists have acted passively or have taken leadership boldly by asking questions, manipulating situations and patient productions, etc.

The beginnings of psychodramatic group therapy evolved from a totally different quarter, i.e., J. L. Moreno's Theater of Spontaneity in Vienna. Moreno found in early experiments that the actor who created his own plays spontaneously tended to mirror "his private world, his personal problem, his own conflicts, defeats, and dreams." Moreno evolved his psychodrama by "systematically developing play as a therapeutic principle." (See *Group Psychotherapy*)

Group therapy, as has been implied, is quite flexible, hence, it may assume the form of the therapeutic modality favored by the individual therapist. Thus the school of client-centered, nondirective counseling developed by C. R. Rogers formed the base for one type of group therapy. From nondirective groups many types of therapeutic clubs, round-table psychotherapies, therapeutic communities, and ward-level groups (in mental hospitals) have been formed.

The tendency toward a leaderless grouping of fellow sufferers has fanned out in such organizations as Alcoholics Anonymous, Gamblers Anonymous, Neurotics Anonymous, which in part were foreshadowed by A. A. Low's training groups for mental hospital ex-patients, "Recovery, Inc.," in 1941.

The distinguishing character of eclectic group therapy resides, as its name indicates, in its freedom to employ one or a combination of usable methods and attitudes. If there is a basic eclectic position, it is this: that therapy as a group transaction is essentially modifiable in response to group needs.

The fact has already been indicated that psychotherapy, as an instrument to improve interpersonal relationships, has spread among social

workers, counselors, personnel workers, and other nonmedical therapists during the last two decades. This is evidence of the democratizing influence of psychiatry and psychoanalysis and the result of the mental hygiene movement, which has familiarized the public with psychological concepts. Thus, group therapy has spread to prisons and to juvenile institutions and it has been used among geriatric patients, labor-management groups, industrial plants, in a variety of ways. One such development has been family psychotherapy. Here, the patient, usually a delinquent or misbehaving child, is seen in the family setting in the consulting room: the child-patient is envisioned as a unit reacting and re-reacting to other units of the family—mother, father, etc. Marital counseling also partakes of the group therapy principles, especially when both husband and wife are seen together and their areas of contention and conflict are explored with the therapist. Similarly, the wives of alcoholics, the mothers of delinquents, and the parents of psychotics are often seen in group settings. (See *Family Psychotherapy*)

From the background of philosophy, several types of psychotherapy have been elaborated. Such a development would be Alfred Korzybski's general semantics in which the influence of semantics on emotions, feelings, and symptoms has been analyzed. Even Gestalt psychology has developed therapeutic techniques in which the growth of a given personality in terms of one's possibly poor perceptive experiences is analyzed and redirected.

Still within the scope of philosophically oriented therapies, account needs to be taken of a relatively new field called existential analysis. Evolving from existentialism as a philosophy, a field of treatment has developed in which the potential capacity of the individual to react "freely" is used to point out a more satisfactory maturation for the individual. Succinctly (if this is at all possible in a philosophic movement), the technique consists in investigating and analyzing each person's reaction to human encounters. In the words of one of the exponents, Henri Ellenberger, "Existential psychotherapy prefers, to the use of psychoanalytic transference, the use of another interpersonal experience, 'encounter'. . . . Encounter is, in general, the decisive inner experience resulting from it for one (sometimes for both) of the two individuals." Existential analysis attempts to understand the world of experiences in the individual rather than his pathological expressions of defenses.

There are numerous other approaches to psychiatry and particularly psychotherapy, stemming from widely diverse theories that have

flowered in recent decades. Among these could be counted Andrew Salter's conditioned reflex therapy, which is based on Ivan Pavlov's theories, pastoral psychiatry, a type of re-education based on communication theory, etc.

Among the many prominent movements in psychiatry during the twentieth century was Adolf Meyer's "psychobiology," the influence of which was perhaps as strong as, but more subtle than, psychoanalysis. Meyer, who for many years directed the psychiatric unit at Johns Hopkins University, regarded mental disease as the faulty response of an organism to the internal and external demands made upon it. He spoke in terms of "reaction types" not diseases, brought "plain sense" into psychotherapy, emphasized habit training, and dealt with the life plan of patients in all its complexities. The psychobiologic attitude, which quietly infiltrated American psychiatry, did not exclude specific treatment such as hypnosis or even psychoanalysis, but it provided a humanitarianism, a perspective, and a balance that has eventuated in modern psychotherapy's interest in the "whole man."

Much of the American concentration on emotional maladaptation as the cause of mental illness, stems from Meyer's "commonsense" psychiatry. Indeed, the de-emphasis of psychoanalysis as an essential part of the scientific psychotherapist's training, is in large part a result of Meyer's acceptance of American pragmatism and practicality, combined with recent advances in pharmacological treatment of mental disorders.

Psychiatry as a specialized field, in the years of its burgeoning, never actually departed from medicine. Early in the present century, medical measures of many types—physiotherapy, electrical stimulation, sedatives, and other drugs—were experimented with regularly in treatment attempts. During the 1920's, such drugs as barbiturates, scopolamine, and Benzedrine, were used to induce "twilight states," and carbon dioxide inhalations, surgical procedures, and a host of new drugs were used to modify neurotic and psychotic reactions.

A mere listing of such methods as insulin shock therapy, electroshock therapy, glandular treatment, and lobotomy during the 1930's and 1940's would necessitate writing a much longer chapter.

By the 1950's derivatives of Rauwolfia were introduced for use in mental illness, and they were followed by numerous other tranquilizer drugs. Suffice it to say that the growing series of chemical compounds called tranquilizers have extended the possibilities of psychotherapy immeasurably. Each month brings new developments in neurophysiol-

ogy, brain surgery, and brain chemistry that may eventually rewrite psychiatry in neurophysiological terms. In fact, the combined use of drugs (antidepressant, mood-elevating, agitation-reducing, etc.) with psychotherapy has almost revolutionized psychiatric treatment at this writing.

Yet, in spite of these startling developments, the basic human enigma of body-mind relation still tantalizes the inquiring psychiatrist. For the complexities of mental life and its disorders are so vast, and the possibilities of new vistas so intriguing, that the history of psychiatry and psychotherapy may well be considered merely a phase in that continuum—The Mind of Man.

HOMOSEXUALITY

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What is homosexuality?

Homosexuality is a sexual deviation, which refers directly to sexual relations between persons of the same sex, and in a general way, to a love relation between two males or two females. It may range from an intense love affair in which sexual relations are a significant aspect of the love relation to a temporary sexual contact without affection, endearment, or tenderness.

Homosexuality is not one regular pattern of sexual activity. For example, both overt and latent homosexuality exist: it is the former with which this article deals since latent homosexuality is more properly a tendency, usually unrecognized by the person who has it. According to Benjamin Karpman, long a student of sexual deviation, the most useful classification is that of active and passive homosexuality. The first group consists of those who are aggressive, possessing, and in Karpman's words, "An attitude more nearly approaching the role of the male in the heterosexual relation," whereas the passive group consists of those who are submissive, approaching the normal female attitude in sexual relationships.

Actually, individual homosexuals do not necessarily maintain an active or passive attitude exclusively in a given relationship, inasmuch as they alternate in the male and female roles. Karpman also makes a distinction between oral and anal types, but this again is not a true clinical distinction. Finally, from a social point of view there are conservative and promiscuous homosexuals, the former seeking and maintaining lifelong relationships with a given man, or woman, as the case might be.

Homosexuals are sometimes referred to as "gay" (the term preferred by homosexuals themselves), "queers," "fairies," "fruit," etc. Women homosexuals are referred to as "Lesbians" or "lesboa." The term "dyke" or "bulldyker," is a vulgate usage. Of course, the term "homo" is commonly used, as are "man-lover" and "woman-lover."

What are the estimated percentages of adult male and female homosexuals in the United States?

Pending the gathering of accurate figures, one can make the broadest guess that about 2 per cent of the male population are or have been homosexual and one-half of 1 per cent of the adult female population are homosexual. It must be emphasized, however, that this is an educated guess viewed from the position of the psychiatrist who handles material of this kind. According to a report by the Cambridge University Department of Criminal Science in 1957, 15 per cent of all homosexuals in England were undetected, the total homosexual population being estimated at half a million. In England, there was an apparent increase during World War II and immediately thereafter, because a greater number of homosexuals were more overt in their activity. This aroused the British law enforcement officers to attempt further control and hence led to some estimation of the number of homosexuals.

According to the (Alfred C.) Kinsey reports, *Sexual Behavior in the Human Male* and *Sexual Behavior in the Human Female*, the percentage of individuals engaging in homosexual activities is higher than that given in our answer. The Kinsey reports state that in the sixteen to fifty age-group, among single persons, 32 per cent of males, and 5.5 per cent of females have had orgasm due to homosexual activity. Among married persons in the same age-groups, the figures are 2 to 8 per cent among males and 1 to 2 per cent among females. It should be noted that these figures indicate the relative frequency of orgasmic activity due to homosexual activities among those persons studied and not to the proportion of all males and females who have had homosexual experiences.

Since Kinsey was interested in orgasmic frequencies due to homosexual contacts, these figures would not serve to answer the question as to the proportion of Americans who have had homosexual experiences. When one considers the entire population, its diverse racial derivations, the various economic and social levels, the disparate cultural and sexual mores among literate and illiterate elements in our population, the uncounted persons whose sexual life is not open to scrutiny—one must conclude that the “educated guess” indicated above is as close as anyone dare come to such an estimation.

In the United States, one can only guess at the undetected number of homosexuals. One should bear in mind that some young persons engaging in homosexual acts, relinquish the practice in their late twen-

ties or thirties. Of these, a small number functioned as homosexual prostitutes for purely mercenary reasons, others were active because of the novelty, and still others engaged in homosexual practices following a period of abstinence, as in prison or in reformatories, or because of a neurotic fear of girls and women. Where the novelty wears off or where the homosexual urge was but one aspect of pansexuality (i.e., the total expression of the sexual drive in any form), growing social maturity in such persons makes homosexual activity less satisfying as they approach their thirties. In this discussion it should be noted that a homosexual "offender," according to police records, may be a confirmed, a casual, or even a once-in-a-lifetime offender, as long as he is caught in the act.

How does the percentage of homosexuals in the United States compare with percentages in other countries?

It is said that there is a higher percentage of homosexuals in the western European countries than elsewhere. However, since reliable figures are so difficult to develop and since prejudice enters into estimations, this writer does not feel that even an approximate comparison can be made with the American population.

Is homosexuality a world problem?

Yes, homosexuality is a world problem, present in every country on the globe. Furthermore, primitive societies have been described as harboring homosexual members, and the freedom of homosexual love among the Spartans in ancient Greece is well known; indeed, it was considered to be a normal phase in the education of Spartan youth.

What is the earliest age at which homosexuality can be detected? How can this be done and by whom? Can parents recognize early signs of homosexuality? What should they do if there is doubt about their children's development?

All children develop interest in the bodies of others from about the ages of four to six. This is a period of "playing doctor" and other games with colloquial names, such as "pantsing," "piling on," etc., in which several boys jump on the victim and against his will, expose his penis. The latter could be the beginning of homosexual practices but in the vast majority of cases, it represents a passing phase of sexual exploration. From the ages of about six or seven to twelve, there are many episodes where boys play with their sexual organs or exhibit

them to each other, and this, to adults, may carry a homosexual coloring.

The only clinically reliable sign of early homosexuality consists in an intense attachment of boys (around the age of fourteen) to older boys and, possibly, a disinclination to engage in body contact sports. Also, in young homosexuals, a persistent preference for female clothes has been observed, including use of such things as perfumes, female underclothing, cosmetics, etc. Usually, these objects are secretly taken from the mother's wardrobe or from the wardrobe of a favored aunt or older sister. This behavior lends credence to the psychoanalytic observation that psychological identification with the mother (similar to the "dressing up" of the five-year-old girl in mother's high-heeled shoes, etc.) represents the psychic root of homosexuality. This may lead to transvestism (sexual pleasure derived from dressing or masquerading in the clothing of the opposite sex), but more commonly is a passing phase in boys who unconsciously ally themselves with their mothers. (See *Sexual Deviation*)

The real appearance of homosexual tendencies can be detected around the ages of fifteen to seventeen. Here, normal masturbation and fantasy interest in women, excitement over the female figure, along with yearning for and seeking companionship of girls, becomes conspicuous by its absence. One must note here that some neurotic youths develop a seeming disinterest in girls, but this is because of shyness, not indifference to their attraction.

The question as to the parents' course of action if a child is discovered to be overinterested in the opposite parent's clothes depends on the particular situation. There is also the danger of overemphasizing the parents' anxiety and misinterpreting the child's interest in clothes as more than curiosity. However, if the child's preoccupation is fixed or increasing, a child psychiatrist should be consulted and the family situation should be studied carefully. Often child phobias (fears) are encountered lying behind an attraction for perfume, clothes, etc., and psychotherapy by a competent therapist may relieve them. Obviously, if interest in cosmetics and underclothes persist to youth or adulthood, intensive psychiatric treatment is indicated.

Can homosexual traits be inherited?

There are no studies of which this writer is aware that point to actual inheritance of deviated sexual traits. The fact that a great many

homosexuals live with male partners and therefore are less likely to have children, automatically cancels this question in some cases.

The question of inheritance of homosexual characteristics implies that the one who inherits them is congenitally disposed. Hence, we ought to deal first with this fundamental and perhaps the most frequently asked question: Is the homosexual born "that way"? Medical opinion is sharply divided although the majority of those working in this area are agreed that homosexuality does not depend on an organic component in the individual. Most psychiatrists, including this writer, feel that glands or glandular products cannot direct the choice of male over female sex objects in the male, or the reverse in women. It is agreed that gland secretion can determine the degree or amount of sexual impulse, that female hormones occur among males as indicated by androgen-estrogen urine levels, and that male hormones occur among females regularly. However, the direction of sexual drive, whether homosexual or heterosexual, is not determined by hormones. Thus, E. E. Mayer, a forensic psychiatrist of experience, says flatly, "Homosexuality is a purely psychologic phenomenon."

On the other hand, some observers, such as George W. Henry, find that many confirmed homosexual men show certain characteristics, such as deficient hair on the body, high-pitched voice, fat pads on stomach and buttocks, feminine pubic hair, etc., more often than do heterosexual men. And casual observation seems to identify a type of small-boned, long-chested, graceful young male within the homosexual ranks. Still other researchers feel that the condition is sometimes due to endocrine factors (about 30 per cent of cases) and otherwise due to psychologic or learned factors. Since the factors requiring analysis are so complex, and social attitudes toward homosexuality so pervasive as to tend to distort judgment, it can be taken as unproved that homosexuality is organic in nature.

For example, there are men who seem to have poor muscular coordination, i.e., who throw a ball "like a sissy," or talk with a lisp. These men might be thrown into homosexual associations by being excluded from active physical play with boys and youths. This latter factor may be congenital in the sense that the neuromuscular structure of these individuals is dysplastic, i.e., poorly (or oddly) developed.

Chiefly, homosexuality develops as a psychological defense against unconscious fear of women with subsequent retreat to men for sexual expression. This is the core of the psychoanalytic theory of homo-

sexuality. The mental mechanisms by which the resultant attitude evolves are complicated. In brief, the boy who is destined to become a homosexual develops a strong unconscious identification with the mother, or mother figure, thus laying the psychological groundwork in early life for a pattern of seeking male love objects. In contrast, the normal boy identifies with the father and hence, in time, seeks a female love object. Early fear of women, in homosexually inclined boys, is observed by their identification with women, the "identification with the aggressor" mechanism. Thus, men become psychologically "safe" for them. These mechanisms are, of course, unknown to the individual but can be demonstrated in a prolonged psychoanalysis of a given case. In addition, environmental influences play a part in this type of misidentification: often families wishing for a girl-child, reject the boy unwittingly. Sometimes this influence is hidden if the predominant family tone is matriarchal in nature. In the case of girls, the reverse of these mechanisms can be observed.

In general, psychological explanations of the homosexual male stress a deep fear of women that is buried and covered over with idealization and idolization of men to the detriment of women. (See *Heredity and Mental Health*)

Is the child who is reared in a home where sex standards are lax likely to become a homosexual?

If by laxness is meant unnecessary immodesty or promiscuity in the home, then the answer is that there is no greater likelihood of homosexuality developing in such an environment. Of course, if the father is effeminate or deviated sexually, this might confuse the identifications of the growing boy. Usually, as in the case of criminal parents, the offspring react away from these tendencies.

Much sex talk in the form of jokes, foul language, etc., by parents and other adults, does not stimulate any particular form of sexuality but rather removes the strength of taboos earlier in life than would ordinarily occur.

Are there physical characteristics that distinguish the homosexual? Are male homosexuals usually effeminate in build and appearance? Are women more masculine?

Usually, male homosexuals cannot be distinguished by their physique except in the case of homosexuals who succumb to "swish,"

where femininity is exaggerated, and thus caricatured. Homosexuals need not necessarily be effeminate in their attitude, dress, or demeanor. Many homosexuals are athletic, virile-looking men with no trace of femininity. Those who are slight in physique or have the structural changes mentioned previously are recognized more easily, and, therefore, give the prejudiced observer the impression that homosexuals are physically different. Homosexuals often boast that they can identify other persons of this group instinctively and at a glance but they are wrong as often as they are right. It is hard to evade the suspicion that the homosexual's frequent misidentification of others as homosexual (or even their accurate identifications) rests on a projection of their own feelings of insecurity. It is generally acknowledged, however, that all men and women carry unconscious homosexual elements within their personality structures. Such elements make for tenderness in men and enterprise and vigor in women, and are therefore socially acceptable. It may be this aspect of the personality that the homosexual intuitively perceives in those he casually encounters.

Are there psychological characteristics that distinguish the homosexual? Do the men sometimes act more feminine than the average woman? Do the women act more masculine than the average man?

Whether or not psychological characteristics of a specific type exist among homosexuals is a moot question. For example, one such characteristic is said to be lack of aggressiveness; another is said to be an increased appreciation of aesthetic enjoyments. Here we must consider the social values given aggressiveness and aestheticism in our culture, particularly in some parts of the United States. Aggressiveness is generally prized by men and tacitly accepted as masculine, whereas aestheticism is not encouraged, by and large, as a desirable trait in a man. Nevertheless, homosexuals accept these attributes and use them in their own thinking to demonstrate, to their own satisfaction at least, their superiority to heterosexual persons. This applies especially to those who live the "gay" life and who indulge in swish activities: dressing in female clothes, exaggerating the female gait, speech, bodily movements, and so on. This behavior is indulged in chiefly by the younger, "prettier" homosexuals or those with theatrical talent, and most often within the confines of their own circles.

Another factor of sociopsychologic import is that the homosexual can gratify sexual impulses without the worry of pregnancy of, or re-

sponsibility for, a woman. Heterosexual life involves many amenities, respect for others' feelings, consideration of social rules, financial outlay, etc., that the young homosexual may be pleased to evade, so that the "gay" life may appear especially attractive.

As to female homosexuals, some of them often do present masculine characteristics, accentuated by male dress. These characteristics are particularly a deep voice and perhaps narrow hips and wide shoulders, but they are by no means uniformly present. Homosexuals of this type maintain a hard, direct, "nonfrilly" attitude, communicating mainly within their own group. Their attitude could be said to be taciturnly masculine. On the other hand, many female homosexuals are feminine, attractive, and soft in the accepted social stereotype.

Is it possible for a person to have homosexual traits or inclinations without consciously knowing it?

All persons have unconscious homosexual components in their makeup, and this is because their parental images were both paternal and maternal. But this does not imply sexual love in the sense of overt homosexuality. Filial, maternal, paternal, brotherly, or sisterly love is certainly normal in nature but psychoanalysis shows that this love is based on unconscious, or latent, homosexual impulses. Perhaps the clearest place to see the emergence of latent homosexual feelings is in the camaraderie of drinking companions when the maudlin stage has been reached. Certainly such men who slobber over each other in brotherly affection would not recognize their latent homosexual feelings when sober. Such men are usually and normally heterosexual. When we say that all men and women are basically bisexual psychologically, we are speaking in the terms explained in this paragraph. Summing up, then: latent homosexual feelings among men and women are quite normal, emerging only in special situations.

But complexities arise in this consideration. For example, if a girl develops a "crush" on an older woman or a youth develops a strong attachment to an older man, it may be an outcropping of homosexual impulses, which, though covered, may eventuate in an actual homosexual experience, or it may not. There are other situations where latent homosexuality asserts itself in ways noticeable to an outsider. Many perceptive individuals, if they are honest with themselves, will recognize an occasional flash, perhaps once or twice in a lifetime, when they experience a fleeting passionate feeling for a member of the same

sex. This feeling may be obscured in admiration for a well-developed athlete, a handsome youth, a warm friend in a mellow mood, and so on. Again, one occasionally observes undue interest in jokes told of homosexuals and a penchant for imitating "gay" people in jest. Also occasionally, engagements that are suddenly broken off without obvious reasons may be due to the upthrust of a latent homosexual feeling warning the affianced that the impending marriage is a psychic threat to him or to her. One sees the same mechanism at work in marriages that go sour within the first year or two notwithstanding creditable sexual life between the married partners. In such marriages, the other partner is aware that something is wrong, but finds it difficult to point to any one area of conflict within the marriage. In such situations, or where they are suspected, professional help should be sought in order to diagnose the psychic situation in either partner of the marriage. However, it should be stressed that there are many factors operating in marital difficulties, and the accentuation, in this article, of homosexuality as one factor, should not be lifted out of context or be given undue consideration.

Do most men and most women have some homosexual experiences at some time in their lives?

Many men have been approached by a homosexual at least one time in their lives, but only a small percentage have had an overt experience. If one adds the times after a drinking bout or a stag party that may have been followed by homosexual experiences, it would increase the percentage a little. Of course, homosexual play among boys from the ages of seven to ten must not be included in this total for this is chiefly a phase of sexual exploration.

As far as women are concerned, not much information is available. The proportion of women who have had overt homosexual experience may be smaller than the proportion of men, but, according to Charles Socarides, of the College of Physicians and Surgeons, Columbia University, "The incidence of overt homosexuality in women is probably just as great—if not greater—than male homosexuality. . . ." Nevertheless, it seems probable that the proportion of women who have been approached for homosexual purposes is small, and those who have had overt homosexual experiences is even smaller, in the general population. Much that might be mistaken for homosexuality on casual glance, turns out to be effusive affection between women, or a

momentary need for kissing and caressing and admiration and transient "gushing" attitudes.

This is an area wherein it is difficult to speak with any degree of accuracy. The psychiatrist is occasionally able to come upon information on this question incidental to treatment of many types of neurotics, but he has little opportunity to study the sexual habits of the majority of "normal" persons to whom this question refers.

What is a bisexual person?

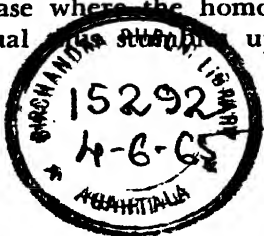
A bisexual person is one who is able to, and does, perform both heterosexual and homosexual sex acts: for example, an active male homosexual who is able to enter into marriage with relative satisfaction, and have children. This term is often used as a cover for homosexuals who for reasons of convenience or social pressure remain married but still maintain occasional homosexual relations.

There are many variations in the life pattern of the bisexual individual. He may have given up homosexuality and adopted marriage under social pressure and may have a sincere wish to succeed heterosexually. He may be more active in one form of sexual activity than in the other or he may have greater gratification (i.e., stronger potency) with a homosexual partner than with his wife and may resort to the former only when under stress or in anxiety, or as an occasional secret "fling." Karpman has pointed out that the bisexual person is under constant conflict because his homosexuality is never condoned by society whereas the heterosexuality is approved. In such a man (or woman) a deep inner need for homosexual indulgence exists.

In this answer, the term "bisexuality" is used as a variant of homosexual conduct in contrast to the absolute or overt homosexual who cannot be sexually effective with a member of the opposite sex.

Is impotence a symptom of homosexuality? Is it a cause?

In the case of male homosexuals, impotence occurs, as it does among heterosexual men. However, this type of failure is less frequent in homosexuality than in normal sex relations. It cannot be considered a symptom of the deviation nor can one say that impotence with women drives men into homosexuality. Occasionally, an impotent man does find himself potent with men, to his surprise and possible chagrin. This would refer to a case where the homosexuality was latent or hidden, and the individual turned upon the fact that he is basically homosexual.



Impotence is usually considered a neurotic symptom and, of course, there are neurotic homosexuals as well as apparently adjusted ones. (See *Impotence*)

The same holds true for frigidity in female homosexuals except that extremely few women move from frigidity in their marriages to female homosexuality. Those few who do move to homosexuality from a poor marriage where sexual life has been inexplicably difficult, usually discover their homosexual feelings accidentally. (See *Frigidity*)

Do male homosexuals tend to dislike women and female homosexuals to dislike men?

In the case of males, they do not dislike women; they accept them and even appreciate them but have no sexual drive toward them. In fact, many homosexuals find the company and conversations of women very congenial. Homosexuals often relate their sexual repugnance for women to their inability to comprehend how they could be exciting or stimulating. It has been noted by some observers that the homosexual has a repugnance for the female genital area.

In the case of female homosexuals, one can say that they more actively dislike men or consider them superfluous to their lives and interests. Their sexual feelings are similar to those of men.

Can a homosexual feel genuine love for another homosexual, or is the feeling based primarily on hatred for himself and the other person?

The love of a homosexual for another is as strong, as full of tenderness and passion, as that felt in heterosexual relationships. It is true that these love affairs do not develop the community of interest around children, family, property, etc., that marriage entails, but while they last, one can distinguish the admiration, idealization, warmth, and companionship that exist in good marriages. It should be noted that sexual passion among homosexuals can be as strong or even stronger than the passion between vigorous adults of opposite sexes. This is especially true of Lesbians. The reasons for this are complicated and have to do with the many emotional and social factors that enter into sexual relations and marriage.

Parenthetically, it may be remarked that the varieties of sexual relations in marriage have never been clinically charted. However, at least this much is known: sexual relations may be indulged in for reasons of anxiety, hostility, frustration arising from some other quarter, fear,

and jealousy. These are neurotic uses of intercourse in which infantile emotional reactions impinge on the adult relation. All this may influence the degree of sex impulse or drive and the resulting gratification deriving from the orgasm.

In the instance of a homosexual relation, only some of these mechanisms are functioning. In addition, as Otto Fenichel has pointed out, "Most homosexuals cannot so easily free themselves of their normal biological longing for women." For when the homosexual is attracted to fair youth, or boys, he is succumbing to his interest in femininity, albeit femininity in an organism equipped with a penis. This apparently is what makes the transvestite exciting to the homosexual—the combination of femininity outwardly with a male organ beneath the female clothes. (See *Sexual Deviation*) Thus the sexual excitement derives from two sources (unknown to the homosexual) simultaneously. As previously indicated, the reason why sexual relations with women is unthinkable to the homosexual is his repugnance for or fear of the female genitals.

In the case of female homosexuals, sexual relations with men is a frightening psychic experience, touching off deep fears of violent injury deriving from infantile experiences. Further, the female's psyche evolves through an intricate development psychosexually because she has had a primary identification with her mother even as she develops an identification with her father. The homosexual girl replaces her father through identification, seeking female sex objects as her father did.

Strength of sexual satisfaction is dependent upon many factors both in the heterosexual and in the homosexual person. As is well known, the type of sex object makes a tremendous difference in the orgasmic gratification of both groups. Perhaps the reported excitement experienced by homosexuals is partly dependent upon their regular promiscuity. The newness of each sex object brings forth the entire train of neurotic factors determining potency and gratification.

There are, of course, casual homosexual contacts where neither love nor outstanding passion is displayed. This would be obvious in the male prostitute situation. Here, in the active partner, considerable sadism may be displayed, but this is part of the total sex drive and not specifically anger against the person. The homosexual may have a feeling of hatred for himself, but this is more prevalent after the act and is related to deep feelings of remorse.

Are homosexuals likely to be more preoccupied with sex than are other people?

This is difficult to answer because in modern life, men and (perhaps less so) women are preoccupied with sex in their fantasies and thinking to a tremendous degree. Preoccupation with off-color jokes, especially when drinking, is a clear indication, as is the extensive interest in "girlie" magazines and pornographic literature. In this sense, homosexuals are just as preoccupied. The total picture may be a sign of our American culture with the heightened value given sexuality or perhaps a sign of our greater freedom with sexual discussion.

Are most homosexuals promiscuous or can they settle down for life with one partner?

They are promiscuous as a matter of proved and accepted tradition. Some do settle down with one partner for life or for a period of years. Promiscuity is more prevalent in the twenty to thirty-five age-group; settling down customarily occurs approximately after the age of thirty.

Many people of genius have been considered to be homosexuals, for example, Walt Whitman, Tchaikovsky, Plato. Is there a connection between homosexuality and creativity?

This question, touching as it does on a dimly understood area of the human mind, has been much debated. Creativity as a human function is said by some psychoanalysts to derive from neurotic conflicts. In this view, a homosexual who is a writer or an artist is creative by virtue of unconscious conflicts within him, which are expressed in his art. Others feel that creativity is a special function of the mind and is related to sexuality only in the sense that mental energy and intelligence are related to creativity. (See *Creativity*) Modern philosophers, such as the German, Ernst Cassirer, relate creativity to the capacity to envision symbolic forms even before they come into language or artistic forms. That is to say, the perception of a symbol (of language or form), its springing to the mind, is itself a process of creation.

It should be noted that creativity and sexual vigor seem to have a positive relation to each other. However, whether a case can be made out for homosexuality itself as a creative agent is quite doubtful. Certainly, homosexuals have among their number men of genius. Similarly,

an impressive list of creative men and women who were strongly endowed in a heterosexual direction could be set up to match the homosexuals of creative capacity.

And what of inventors and scientists or entrepreneurs? We must remind ourselves that the word "creative" is commonly used to denote the work of artists and writers. Since many homosexuals are interested in art as a general field, there is a tendency to identify one with the other. Further, in this group of writers and artists are many persons who, inhibited from forming emotional ties or stable love attachments, may on occasion turn to homosexuality for sexual expression because of their voluntary self-exclusion from ordinary society.

It remains to be stated that there are some men who appear to have a decreased sexual interest in women. These can be religious persons, those with a specific philosophical outlook, hermits, embittered persons, recluses of many types—and these men may be miscalled homosexuals. Such people are classified by public convention (which demands that a man declare himself as homosexual or heterosexual) into a specific category, sometimes that of homosexuality.

For these reasons it cannot be said that there is a valid bond between homosexuality and creativity, or homosexuality and high achievement.

***Do a high percentage of homosexuals seek employment in the arts?
Do homosexuals tend to gather together?***

Because of the obvious factor of selection, based on the wish to be associated with each other, homosexuals in large numbers enter the theatrical profession or become garment designers. On the other hand, no profession is immune. Homosexuals are found among physicians, lawyers, teachers, athletes, bankers, publishers, musicians, salesmen, and so on. Perhaps in the larger cities, the effeminate type of homosexual tends to predominate in "arty" fields, but there are many deviates in rural and small-town areas. The homosexual who likes to live the "gay" life tends to associate with his own fellows, restricting his social life to his own coterie in specific places of amusement, bars, restaurants, etc. It might be assumed that the contact sports or activities where men are thrown together would be a fertile field for homosexuals. Actually, overt homosexuality is relatively rare in professional sports, military life, the merchant marine, etc.

Trying to narrow down the areas where homosexuals congregate becomes difficult as one surveys the total field. Moreover, the articulate

and sophisticated deviates are more likely to seek each other's company openly. This is certainly true in the case of Lesbians.

Are homosexuals usually of higher intelligence?

In general, the answer is, "No." Sophisticated homosexuals are prone to think of themselves as superior to heterosexual persons because their interests run counter to those of the latter. Since conversation and witty gossip are among the chief pleasures of the "gay" group, whereas action in sport, work, or hobbies is more ego-satisfying to heterosexual men, the former emphasize their linguistic fluency and familiarity with psychological matters as signs of superior intelligence. Much of the professed superiority of deviates of the homosexual class represents a defense against deep feelings of rejection by society.

As to the nonsophisticated homosexual, his intelligence can be equal to that of any other person, being neither higher nor lower than the average on his professional level.

Can homosexuality be treated and eventually cured?

The treatment of homosexuality is difficult and time-consuming. Ordinary methods of persuasion, suggestion, even hypnosis are of no avail. The only practical method is that of intensive psychotherapy on psychoanalytic principles, which seeks first to establish a transference between patient and therapist and then to probe into the early emotional relationships of the patient. Modifications of therapeutic methods are required; for example, in many cases the couch is not used, a freer relationship between therapist and patient is encouraged, the therapist may be more directive, and so on.

In recent years group therapy has been employed both in institutions and in office practice, where patients openly discuss their feelings, backgrounds, and histories with the group leader. Naturally, all cases must be viewed in the light of their individual history and personality makeup. The theory on which treatment is based can be summed up by Karpman's statement in a recent issue of the *Archives of Criminal Psychodynamics*: "Homosexuality and perversions . . . appear as brothers under the skin for they stem from the same sources and roots, namely, neurosis."

The question of willingness to be helped is a major one in the treatment of homosexuals. For instance, there is a small group of homosexuals who have no wish to be helped inasmuch as they are convinced

that they are congenitally endowed with feminine tendencies. Some medical people feel that this group is, in fact, incurable. However, a larger experience indicates that this feeling of inevitability concerning a life of sexual deviation arises partly from the physician's unconscious bias against the deviation and partly from the insistence of many homosexuals that they remain as they are.

The actual channel through which a person comes to treatment may be significant. For example, if a relative of a homosexual insists that he seek treatment, that emotional relationship may be exploited to seek the neurotic cause underlying the deviation. Although ordinarily the homosexual does not himself seek aid, a minor depression or neurotic symptom may force the deviate to consult a psychotherapist. In a recent case, a Lesbian fell into a deep depression centering on the question of her social nonacceptance when her partner decided to marry a man.

Are there other approved methods of treatment for homosexuality?

To consider the grosser forms of treatment first: (1) imprisonment, which has of course been accepted as a form of management, and (2) surgery, i.e., castration or sterilization, which has been urged by a few persons. It is obvious that incarceration in a penal institution will do nothing but remove the offender from society for a while, and castration just as obviously does not remove the sexual drive even though it removes the possibility of orgasm. Castrated individuals may display other types of sexual deviation. Sterilization, i.e., the operation (on men) known as vasectomy, does not reduce sexual drive but merely limits procreation. All authorities agree unanimously that imprisonment per se contains no therapeutic principle or effect. More recent programs of group therapy and counseling, such as those actively carried out in California institutions, do provide a therapeutic atmosphere in prisons of special state hospitals.

The goal of most institution psychiatrists is limited to helping homosexuals reduce their anxieties, modify their social patterns, and hasten their emotional maturation. In such cases the return to society and to social groupings after hospitalization should be carefully supervised by social workers. Mental hygiene clinics and occasional visits to psychiatrists help to maintain the gains made in the state hospitals.

Other methods of treatment—borrowed from the treatment of mental patients—have been used on homosexuals. These include shock treatment, drug usage, occupational and recreational therapy. Not much

can be expected from these techniques. As to hypnosis, it has been stated earlier in this article that it was unavailing. This answer probably represents the viewpoint of most psychiatrists although nonmedical hypnotists may claim successes. More recently therapists in England have attempted the conditioning treatment following along the lines of the Pavlovian conditioned reflex theory. In this treatment the patient is exposed to a form of homosexual stimulation (pictures) and coincidentally given an electric (galvanic) shock, or a drug inducing nausea, or other painful stimuli with the hope that a conditioned reflex against homosexual excitement would develop. Only a few cases have been reported, and judgment as to this treatment must be held in abeyance.

In summary, the treatment of homosexuality is difficult, slow, and requires patience and ingenuity on the part of the therapist. Many competent therapists have reported successes, some have reported diminution of sexual activities and reduction of anxiety, and all have experienced failures.

What are the effects of Judeo-Christian ethics on attitudes toward homosexuality?

The influence of religion, especially the Judeo-Christian tradition, is strongly against any type of sexual deviation. This attitude arises from the injunction that the sexual impulse be used exclusively for purposes of procreation. The Old Testament injunction that "man should not spill his seed upon the ground" is pointed toward masturbation. Indeed the whole trend of Jewish ethics interdicts any sexual activity except heterosexual relations within marriage. Prohibitions against uncleanness of the body support this ethic. The Christian view is equally adamant in condemning sexual relations except for purposes of procreation: St. Augustine wrote of the difference "betwixt the self-restraint of the marriage covenant, for the sake of issue, and the bargain of a lustful love. . . ."

The problems implied in this question apparently revolve around whether the clearly stated attitudes of religion are sufficient to modify homosexual drives. At times one sees among practicing homosexuals guilt reactions and depressions arising out of religious conviction, but this is a relative rarity. From the standpoint of treatment of deviations, religious exhortation seems to be of little effect. Apparently the generally restrictive attitudes of the Judeo-Christian codes have little influence on the degree or extent of sexual deviation.

Can an individual be arrested or put into prison or a hospital because of his homosexual practices? How might punishment or the threat of punishment affect the homosexual emotionally? Would changing these restrictive laws be desirable?

The laws governing homosexuality differ in various states. Often they cover all types of deviations without specific references to homosexuality as such. Furthermore, many state laws make no reference to female homosexuality. Chiefly, offenses against public decency, offenses against minors, offenses associated with force (anal intercourse), or disorderly conduct (as in the case of transvestites), or open soliciting for homosexual acts, are indictable and punishable crimes. In general, homosexuals falling into these punishable groupings are punished by long sentences. Many states have provisions for treatment of homosexual offenders in special state hospitals. (See *Sexual Psychopaths and the Law*) As a matter of practice, homosexuals are often tolerated if their activity is not blatant or such as to incite or influence the young. As far as one can tell, punishment exerts only a minor influence on curbing the sexual drive of deviates, although it is clear that homosexuals are sensitive to the possibility of punishment.

Most psychiatric authorities agree that laws governing sexual misconduct should be modified and their inequities reduced. Legal experts, recognizing the responsibility of the courts and police agencies to protect the public, also agree that a distinction between practices that are dangerous, such as homosexuality with minors, and other practices, such as relations between adult homosexuals in privacy, should be made in the law and in legal practice. The consensus of psychiatric opinion as summed up by Karpman recommends (a) lessening of penalties for homosexuality, (b) recognition of psychiatric problems among homosexuals, and (c) thoroughgoing attempts to treat those amenable to therapy. Both psychiatrists and legal experts agree that a tremendous amount of educational work needs to be done before these aims can be brought into line with public feelings and with the law.

HORMONES AND BEHAVIOR

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What are hormones?

Hormones are a variety of discrete chemical substances secreted into the blood by certain endocrine glands, which have a specific effect on the activities of other organs. Hormones affect behavior and regulate and maintain the complex chemical adjustments within body organs, necessary for the maintenance of life, the preservation of well-being, and the capacity to make efficient adaptations to life situations and stresses.

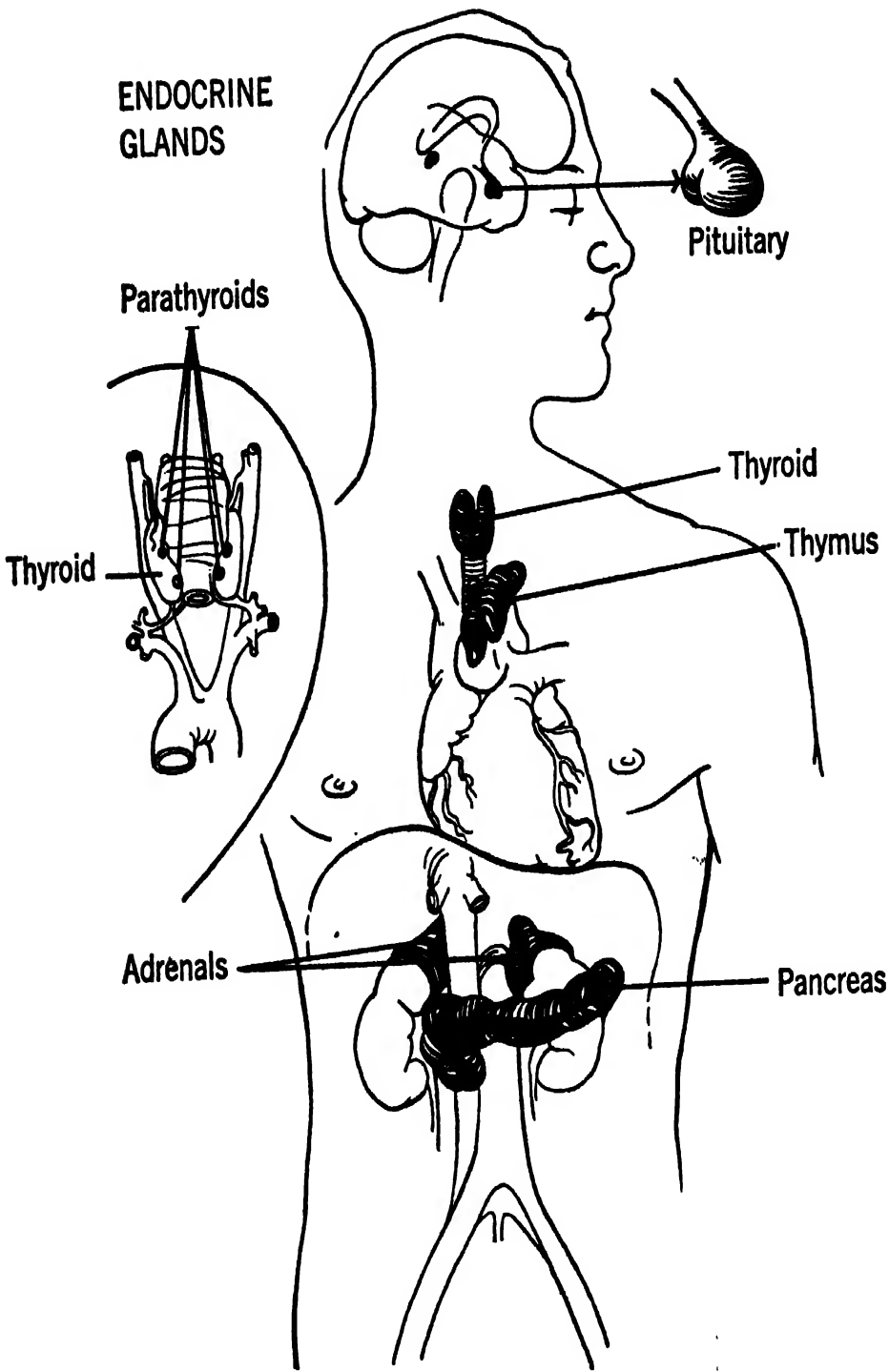
What are the various male and female hormones?

Androgens (androsterone, testosterone) is the generic term for the various chemicals secreted by the testes and the adrenal cortices, referred to generally as male hormones. There is a spectrum of such steroids which have greater or lesser potency as measured by their ability to induce primary and secondary male characteristics.

Primary male characteristics describe the anatomical and physiological development and function of the male reproductive organs. Secondary male characteristics refer to such distinguishing gender features as body build, distribution of fat, growth and pattern of hair distribution, pitch and timbre of the voice, size and strength of muscles, etc.

Female hormones secreted by the ovaries and the placenta in pregnancy are generically termed *estrogens* (progesterone and other estrogens). They influence the development of primary and secondary female characteristics: female anatomy and physiology such as ovulation and estrus (the cycle of changes in the female genital tract which are produced as a result of ovarian hormonal activity resulting in menstruation or permitting the possibility of pregnancy). In addition, estrogenic influences are grossly evidenced by the characteristic female features including breast development, skin texture, hair distribution, etc.

**ENDOCRINE
GLANDS**



What are the functions of the male and female hormones?

In effect they constitute the chemical environment of masculinity and femininity necessary for the growth, development, and maturation of gender characteristics. In addition, hormones regulate to some degree such metabolites as nitrogen by which living tissue is produced and maintained. Anatomical and physiological masculinity and femininity are produced and controlled by a complex series of continuing chemical actions on body tissues. Also, they indirectly regulate growth and serve as metabolic regulators controlling the relative proportion and distribution of muscle to fat mass. Similarly their catalytic function affects the skin and its appendages (hair, nails, sebaceous glands, etc.) by influencing the secretion of skin glands, by controlling hair growth and distribution, and by regulating the development of breast tissue. Indirectly they modify behavior by setting the physiological stage necessary for sexual activity in all of its dimensions.

Androgens and estrogens exist in certain relative proportions in both sexes, and at different ages and physiological states in each sex. The balance among these several kinds of hormones in turn determines the functions of the other endocrine glands, which operate interdependently to control the various organs and systems. The resulting ebb and flow of interlocked hormonal tides account for the advent of puberty, the possibility of regularly recurring menstrual cycles, the possibility of pregnancy, and the development of sexual potency and libido (sexual desire).

What are the endocrine glands?

These are ductless glands or the glands of internal secretion (pituitary, thyroid, parathyroid, islets of Langerhans, pancreas, adrenals, ovaries, and testes) whose function is the formation and secretion of hormones.

While each endocrine gland has its own specific role and function, they are all interrelated by a series of intricate chemical links, which constitute a system of checks and balances. The resultant state of homeostasis (equilibrium) is a flux of constantly changing control and governing mechanisms on which the regulation of life processes depend. In this sense the endocrine glands are integrated chemostats; as such, for example, they control the level of blood sugar despite the periodic intake of large amounts of food on the one hand, and the demand for a rapid conversion and release of its energy incidental to work, on the other.

Which hormones do the various glands produce?

A. The anterior pituitary hormones are proteins. They include: the *growth* hormone (somatotropin, S.T.H.), which regulates skeletal growth; the *luteotrophic* hormone (L.T.H., prolactin), which controls the secretion of breast milk; the *follicle-stimulating* hormone (F.S.H.), which stimulates the growth and maturation of the ova-containing graafian follicles in the ovaries and the tubules in the testes which give rise to sperm; the *luteinizing* hormone (L.H., interstitial) which, in the female stimulates the formation of ovarian structures necessary for the maintenance of pregnancy; in the male it stimulates testicular structures necessary for the formation of androgens; the *thyroid-stimulating* hormone (thyrotropin, T.S.H.), which stimulates the thyroid to secrete its hormones; the *adrenocorticotropin* hormone (A.C.T.H.), which stimulates the adrenal cortex to the secretion of at least thirty steroids.

B. The posterior pituitary (neurohypophysis) produces two hormones: the *antidiuretic* hormone, which controls water balance; and the *oxytocic* hormone, which controls the contraction of the smooth muscles of the uterus and the breast.

C. The thyroid secretes two major hormones: *thyroxin* and *triiodo-thyronine*, which are responsible for the regulation of cellular oxidative processes and hence are the heat generators and regulators of the body.

D. The parathyroid glands secrete a hormone which controls calcium metabolism and thereby determines the chemical composition and structure of bones.

E. The islets of Langerhans are nests of cells within the pancreas responsible for the secretion of insulin, which regulates carbohydrate metabolism.

F. The adrenal cortex is the outer layer or bark of the adrenal glands, and thirty steroids are known to be secreted by it. In general these influence three functions: the regulation of electrolytes, the regulation of protein, fat, and carbohydrate metabolism, and the regulation of androgenic activity.

G. The adrenal medulla is the inner core of the adrenal glands. It secretes *epinephrine* (adrenalin) and *norepinephrine* which, with elements of the autonomic nervous system, control the extensive physiological mechanisms for flight and fight reactions.

H. The ovaries secrete several kinds of estrogenic (female) hormones which are responsible for physiological feminization—menstruation and the possibility of full-term pregnancy.

I. The testes secrete several kinds of androgenic (male) hormones

which are responsible for physiological masculinization and the possibility of fertility (the production of normal motile sperm in adequate number).

J. There are other endocrine tissues (e.g., the pineal gland and the thymus) and functions which are less important and about which comparably detailed information is not known.

Do the workings of the endocrine glands have a relation to ordinary psychological conflicts? If so, what is it?

In the usual sense of "ordinary," they have not. In a tangential way there is an intimate relation between the normal physical appearance and functioning well-being of a person and his "psychological conflicts." Obviously, endocrine diseases such as gigantism (overfunction of the anterior pituitary gland), or adrenal cortical tumors which produce a masculinization of females, or diabetes, or a marked degree of thyroid underfunction (myxedema), or thyroid overfunction (exophthalmic goiter), may produce a profound psychosocial dislocation in the adjustment of the patient as a result of an impairment of his physical capacity or the imposed limitations on his ability to perform or conform to the role society expects. A sensitive reaction to this obvious difference not only can initiate emotional conflict but also is likely to intensify latent insecurities, anxieties, and doubts. Very rarely, however, a deficiency or an excess of a hormone is itself directly responsible for a radically altered physiology, which in turn is accompanied by psychological conflicts. Thus, untreated cretinism (the congenital deficiency of thyroid function) is responsible for mental retardation with its understandable quota of conflict.

Are hormones useful in the treatment of fatigue? Are they useful in the treatment of other states of behavior? How?

Only in relatively infrequent endocrine diseases are hormones useful in the treatment of fatigue. Unrecognized or uncontrolled diabetes, Addison's disease (due to a deficiency or hypofunction of adrenal cortical hormone characterized by an overpigmentation of skin and mucous membranes, muscular weakness, low blood pressure, loss of appetite), myxedema (due to a deficiency in the functioning of the thyroid, characterized by lethargy, apathy, and swelling of the face and hands), tumors of the pancreatic islets of Langerhans, are typical diseases in which fatigue is a prominent symptom. The remedy of the basic condition by appropriate medical or surgical treatment relieves this symptom.

In the vast majority of patients, however, complaints of fatigue are found to have no demonstrable evidence of relevant physical pathology, and therefore do not require the use of hormones in treatment.

In those established instances of hormonal deficiency or excess, careful medical supervision of the hormonal therapy is imperative if serious untoward consequences are to be avoided. In all other instances hormone treatment is contraindicated.

What characteristics of behavior are directly related to hormone control?

There are none that are unequivocally specific.

Frank Beach, a Yale investigator, summarized it thus: "Every behavior is an expressed reaction to both internal and external stimuli. The characteristics of the expression are determined jointly by previous experience, genetic constitution, as well as by the specific metabolic response to the hormone."

Do certain endocrine diseases affect behavior? Which ones? How?

Behavior is affected by the degree to which the patient is conscious of, and reacts to, the "difference" he feels when he is burdened by the gross and subtle stigmata of endocrine disease. The forms these take may be any of a range of possible reactions. At one pole is a frank, realistic acceptance of the situation as it is, without disproportionate anxiety, guilt, depression, or insecurity. The less facile adjustments include all kinds of reactions ranging from those of shy, withdrawn secretiveness to the bitter, paranoid hostility of a Richard II who continually rebelled at being "rudely stamp'd."

It is an invidious task to choose among deformities and defects one which can be borne more gracefully than another. Each endocrine disease has its own built-in ordeal, if its possessor sees and adjusts to it that way. Is the skin pigmentation of Addison's disease more easily tolerated than the protruded eyes of hyperthyroidism or the facial hirsutism (abnormal hairiness) of adrenocortical virilism in women, or the beardless, breasted lot of some male castrates? The significant feature is that all behavioral effects are relayed through the personality of the patient.

What are the relationships between virility-femininity and hormones?

Since the anatomy and physiology of masculinity and femininity are dependent upon an adequate supply and balance of hormones, their

presence is obligatory for wholly normal sexual maturation, appearance, and functions. However, in the human animal, gender role and function is determined in a larger measure by psychological tides than by hormonal ones. This is to say that psychological values, attitudes, emotional experiences, patterns of rearing, in sum, the kind of a person the patient is, have dominant influence in the determination of the adequacy and the direction of psychosexuality which underlies the expressions of virility and femininity.

Can emotional stress cause a disease of the endocrine glands?

The best informed answer to this question is an equivocal one. Scientific evidence has not yet firmly established, nor is it generally accepted, that emotional stress, acute or chronic, can cause endocrine disease. On the other hand, there is much inferential, indirect evidence that suggests a relation between emotional stress and the physiologic function of certain endocrine glands. Certainly fluctuations in the stability of clinical endocrine states reflect the patient's tolerance of emotional stress. In some instances amenorrhea (absence or stoppage of the menses) follows acute emotional stress. Similarly acute emotional deprivation has been noted to precede the onset of certain hyperthyroid states. There is great difficulty in dissociating the invariable physiological accompaniment of stress with its consequent demonstrable effects upon target endocrine organs from purely psychological factors.

Do the endocrine glands cause psychosexual deviations such as homosexuality, nymphomania, frigidity? Is there a possibility of hormone cures?

Fuller Albright, a distinguished Harvard endocrinologist, has written that he "has yet to see a homosexual patient in whom the trouble was based on faulty endocrine function, or in whom the direction of the libido was influenced by treatment with hormone."

He elaborates upon these observations by a somewhat facetious reference to what has become known as Forbes's Law at the Massachusetts General Hospital: A patient who complains of impotence or any lack of libido does not suffer from a hormone lack.

Does the administration of hormones sometimes have undesirable effects? If so, what are they?

By definition, hormones are potent biological substances. In therapeutic doses they always have significant effects on the tissues and

metabolites of the body. Except when they are administered judiciously to replace a deficiency (e.g., insulin in the management of diabetes, thyroid extract to alleviate the signs and symptoms of myxedema), or are purposefully prescribed as a therapeutic adjunct in the control of the virulent symptoms of other diseases—e.g., adrenal steroids in the treatment of the frequently fatal collagen diseases—they may be accompanied by undesirable effects.

Certain steroids have been demonstrated to have carcinogenic (cancer-producing) properties. The administration of certain other steroids to pregnant women for the control of uterine bleeding, for example, can result in the production of genital anomalies in the fetus. Cortisone and other steroids related to it, can produce a clinical condition indistinguishable from Cushing's disease (hyperfunction of the adrenal cortex) with facial hirsutism, a buffalo-type obesity, decalcification of the bones, high blood pressure, etc. Gastrointestinal ulceration and serious blood electrolyte disturbances sometimes accompany the use of steroids. Excessive amounts of female sex hormone can result in chronic uterine bleeding. Conversely androgens can stimulate hirsutism in the female.

Do natural and surgically induced changes in the endocrine glands result in psychological disturbances?

Natural changes in the endocrine glands are normal physiological events which take place over a sufficient period of time to allow the body to accommodate to the induced changes. All else being equal, natural changes do not directly cause psychological disturbances.

Surgical changes precipitate more or less acute alterations in the otherwise carefully balanced state of metabolic affairs. If the induced deficiency states which result from the absence of essential hormones are not compensated, pathological states ensue. Some of these are associated with psychological disturbances (e.g., psychoses with myxedema, Addison's and Cushing's diseases).

The cause and effect relations are complicated further by whatever emotional state may have accompanied the need for the surgery or the stress of the surgery itself, as well as the emotional reaction to the results of the surgery.

Natural and surgically induced menopause has been alleged to cause the so-called involutinal depressions in the female. There is no scientific evidence to justify this assumption. Also, the treatment of these psychiatric conditions with sex hormones has been shown to be ineffec-

tive. However, hormone substitutes for the removed female sex glands can relieve such postoperative symptoms as hot flashes. Here, too, there is evidence that the most important factor is not the alteration in the hormones per se, but rather the meaning of the experience to the patient and her response to it. The psychological component of the menopausal syndrome is accompanied by mild, moderate, or severe emotional symptoms in the largest measure because of the past and present psychosexual adequacy of the patient and not the level of estrogenic hormones.

Can ill functioning endocrine glands cause obesity?

The only established cause of obesity is the rare condition of Cushing's disease. It is associated with a tumor or overdevelopment of the cortex of the adrenal glands and may also produce changes in the anterior lobe of the pituitary. The patient characteristically has an obesity which is truncal in distribution (buffalo-type) with thin extremities as well as a moon face. Endocrine malfunction is alleged frequently, but in these instances, as well as in the most common form, the cause of obesity is overeating.

Do synthetic hormones cause emotional disorders? Directly? Indirectly?

Synthetic hormones serve the same physiological function as their naturally occurring biological counterparts. For the most part, on a weight for weight basis, they are more potent. Therefore, they are likely to exert their effects more rapidly and to a greater degree. The behavioral effects are produced both directly and indirectly. Psychological stability is predicated upon the relative fixity of events in the internal and external environments. Any rapid change in either area constitutes a stress that has to be met by the adaptive powers of the organism. The use of potent synthetic hormones effects the change which takes place in behavior by undue, rapid shifts. The probability of its occurrence is a function of the adaptive capacities of the patient.

Can ill functioning endocrine glands contribute to alcoholism?

The critical word here is "contribute." Dependence upon alcohol may be rationalized by attributing to it any emotional stress, real or fancied. The anxiety which stress provokes is found to be temporarily lessened by the drug effects of alcohol. Endocrine disease, which is intolerable for the many persons previously suggested, may, therefore,

indirectly play a part in promoting a set of psychological circumstances conducive to alcoholism.

What does recent research indicate about the future importance of hormones in the treatment of emotional disorders?

While research in endocrinology sheds progressively more light on the behavior of persons in response to radical changes in body build, appearance, and metabolic balance, it does not promise to yield information on hormones which will be directly applicable to the treatment of emotional disorders unassociated with endocrine pathology.

HOSPITALIZATION

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What does hospitalization mean?

As here used, hospitalization includes any lawful means of lodging a person in an institution for the care and custody of mental patients, whether by formal legal proceedings, by voluntary action of the patient, or by procedure for temporary or emergency commitment.

What may be the reasons for hospitalization?

Until almost the middle of the twentieth century, the purpose of hospitalization was principally custodial, that is, to house and restrain people who were so mentally ill that they could not be cared for by themselves or by their families. Today the primary purpose of hospitalization is treatment. Since the advent of drugs and other new techniques, about 90 per cent of all patients recover or improve enough to be released in less than a year.

What qualified persons or organizations are available for consultation to a person who thinks he may need hospital care, or by someone on his behalf?

Most qualified, of course, is a psychiatrist (a doctor of medicine specializing in mental disorders). Clinical psychologists and school guidance counselors also have relevant training. But the first person to consult is normally the family physician. He can determine whether a specialist should be called in. Among the organizations that can provide advice are the Family Consultation Service, a child guidance center, a local chapter of the Mental Health Association or the Association for Retarded Children. In small communities where none of these is available, local representatives of the State Department of Public Health or Department of Public Welfare may be helpful.

Is it possible for a layman to recognize the signs of mental illness in another?

Not easily, especially in the early stages. Mental illness takes many forms. Most of them are not as dramatic as raving mania. Since the

onset is usually slow, we may not notice the change, especially in a relative whom we see daily. When behavior undergoes a serious change—when a formerly happy person begins to brood, to sit silent and depressed, or to find sinister meanings in innocent words or acts of other people; when a formerly serious and responsible person begins to indulge in reckless, silly, or irrational conduct, or a frugal person starts squandering money on wild buying sprees or on grandiose get-rich-quick schemes; if a calm person is now subject to furious rages—a doctor should be consulted.

What are the fears or feelings that keep a family from hospitalizing a relative in need of treatment?

Love for an afflicted relative may cause members of the family to rationalize his peculiar behavior and convince themselves that he is merely “run-down” or “upset,” and that all he needs is a rest or a change. Also, some people feel a sense of shame or disgrace to have mental illness in the family. This may lead them to postpone treatment with the tragic consequence that persons who with prompt care might have been quickly restored are allowed to sink into a serious and even hopeless condition. This old attitude is fortunately changing and people are coming to recognize that mental illness is not more disgraceful than physical illness.

How may the prospects of hospitalization affect the patient's attitude?

A patient who is seriously disordered may not comprehend his own condition or the significance of hospitalization. But one who is able to comprehend may be depressed or frightened by the prospect of being sent to an “insane asylum,” especially if he has erroneous notions of what life in a modern mental hospital is like, and fears he may never be released. Most mental hospitals today are not “snake pits.” A prospective patient (or at least his relatives) might be cheered by visiting the place. They would probably also be cheered by the institution's statistics concerning the average length of stay.

Have conditions in mental hospitals improved in recent years?

During the years 1945–1950, Albert Deutsch and others exposed “the shame of the states” in allowing mental hospitals to become dumping grounds where unwanted people were “put away” and left to vegetate in vile and filthy surroundings. Since that time, almost all our hospitals have attained at least minimally acceptable levels of humane

care. Their purpose has changed from mere custodial care to cure or rehabilitation, so that patients may again take their place in free society. The old fear that most psychotic patients present an escape danger and so must be kept under close restraint has almost disappeared. Also, locked wards and mechanical restraints for violent patients have been rendered largely unnecessary by the advent of tranquilizing drugs. These have also made it possible to treat most mental patients in general hospitals. Since World War II, psychiatric services in general hospitals have increased markedly. In the near future, most mental patients will probably be able to obtain treatment in general hospitals in their home communities instead of having to go to one centralized state mental hospital. But many hospitals, unfortunately, are still too overcrowded and understaffed to offer any effective treatment program. Even in the better hospitals, the staff is typically less than adequate.

Another recent development is the day hospital and the night hospital. Unlike most hospital patients, those suffering from mental illness need not always remain in bed. On the contrary, the best treatment usually requires that they be up. Some will need to spend the daytime hours at the hospital undergoing therapy, but will be quite able to go home nights. Others may be able to hold a job during the day, but should not be subjected to a family environment that causes tensions, and so may need to spend nights in the hospital.

In many places, however, the old order is still all too prevalent. The Expert Committee of the World Health Organization reported that "most existing legislation is misdirected in its aim. It is concerned too much with placing checks on the mental patient and his physician, and too little with the public's responsibility for providing services for the mentally ill."

May a person in need of mental treatment enter a hospital voluntarily?

Yes. In almost every state today a person able to recognize that he is mentally ill may voluntarily apply for admission to the state hospital. In some states a person not actually ill but merely showing some symptoms of mental illness may ask to be admitted for observation and diagnosis.

The modern trend, perhaps best represented by the British Mental Health Act of 1959, is to encourage patients voluntarily to seek treatment, not only in the hospital, but also in local facilities. The British Act implements this policy by minimizing procedural formalities necessary for voluntary treatment and by encouraging general hospitals to

receive patients suffering from any form of mental disorder. Instead of using designated hospitals and segregated treatment, mental health is now dealt with in Britain, so far as possible, as an integral part of the work of the National Health Service. With the changing public attitude toward mental illness and with advances in therapeutic techniques, an ever-increasing proportion of patients can be treated as outpatients, without compulsory hospitalization.

What are the qualifications for admission as a voluntary patient?

Most state statutes provide that application for voluntary admission must be accepted by the hospital staff after it is determined (1) that there is room, and (2) that the person will benefit by hospitalization. In many states, if a person is found eligible, no physician's certificate or other prerequisite is required.

May children be voluntary patients?

In many states, the parents or a guardian of a minor may make application for his admission under the voluntary procedures.

May a patient who was admitted voluntarily demand release at any time?

Yes, except that the hospital is usually allowed a certain number of days within which to comply. Two opposing objectives come into conflict here. On the one hand, the whole purpose of the voluntary admission device—to encourage patients to seek treatment for themselves—would be impaired unless they were assured that such treatment would continue only so long as they wished. On the other hand, complete freedom to leave the hospital at any time would almost certainly lead to a number of patients leaving a few days after being admitted, because restlessness and disenchantment with the restraints of institutional living are natural, especially during the first days of adjustment. This would make a total waste of the time and effort spent on these patients.

Most states meet the problem by providing that a voluntary patient shall be released within a specified number of days after he gives written notice of his desire to leave, unless, in the meantime, the hospital authorities institute formal proceedings for compulsory commitment. Even this last may seem a violation of the principle of voluntariness, but it is hardly avoidable; no state can be expected to adopt a rule requiring the hospital to release a person who appears to be dangerous to himself or to others.

New York State has added another rule to prevent premature demands for release: it requires the applicant for voluntary admission to sign an agreement that he will not demand release for at least sixty days. Whether this agreement would justify holding him, if within the sixty days he nevertheless demands release, is doubtful, although it presumably would, at least in theory, subject him to liability in damages if the hospital should choose to sue him for breach of contract. But the written agreement no doubt has some practical, if not legal, effect in curtailing demands for release.

May a person be sent to a mental hospital against his will?

Yes. However, the law requires that this be done in conformity with prescribed procedures.

When may this be done?

Statutes usually allow this when the person is so ill that he is likely to injure himself or others if allowed to remain at liberty. Many states also authorize compulsory hospitalization of persons who need treatment and will benefit from it, but who because of their illness lack sufficient insight or capacity to make a responsible decision with respect to hospitalization.

What is the procedure by which hospitalization may be ordered?

In most states, the order must be by a court, following a trial on the question of whether hospital care and treatment are needed.

Proceedings are started by an application which, in some states, may be made by any person; in other states, by persons such as a relative, a physician, or a designated public official. It is usually required that the application be accompanied by a physician's report stating that he has examined the person named in the application and that hospital care and treatment are needed.

In about nine states, the determination of whether or not the person should be hospitalized is made on the basis of an examination by two doctors; if the person objects, he then has the right to a judicial hearing. In a few other states, commitment is by a commission made up of medical experts, or of two physicians and one lawyer. But in most states, the hearing is before a court. The statutes typically require the court to appoint physicians to examine the person. This examination is usually informal and may be held at the person's home or wherever he may be.

The diagnosis of the examining physicians, and perhaps of other experts, is introduced at the hearing.

In ten states, a person being examined for commitment may demand a jury trial. In Alabama and New Jersey, such a trial is discretionary with the court. The jury trial, although usually written into statutes as an added protection against the danger of "railroading," probably does more harm than good. The natural reluctance of families to expose "private troubles" in a public hearing is increased when the hearing becomes a full-dress jury trial. The traumatic effect upon the person being examined, who has to sit through a trial, which to him may have all the earmarks of a criminal prosecution, may powerfully reinforce any delusions of persecution he may have. A jury of laymen may not be qualified to pass upon a question of medical diagnosis. Studies have shown that juries make more mistakes than do judges or commissions of medical experts.

We should not, however, go to the other extreme and say that the determination of whether a person should be sent to a hospital is wholly a medical one. It is a policy determination, resting on social value judgments. The medical expert may be able to tell us whether the person is suffering from a mental disorder, and whether he is likely to behave in a dangerous or antisocial way. But this information will not necessarily tell us whether he should be sent to the hospital. Suppose he is a truck driver whose mental illness is a mild neurosis—which, however, renders him accident-prone? Suppose he is suffering from a depressive psychosis which is highly likely to lead to suicide, but not to any danger to others? Suppose also that the state hospital is overcrowded, so that commitment of any one person leaves less room and less time for others? Although the medical expert can provide the data necessary for a sound decision, his training does not specially qualify him for weighing the competing social values involved. This calls rather for the kind of competence and experience that we expect of a judge. Moreover, confining a person against his will abridges a fundamental human freedom, and should not be permitted without fair procedure. It is therefore understandable that except in emergency situations most states permit such confinement only on a judicial order.

The trend, however, is to make use of judicial proceedings only where fairness demands, and wherever reasonable to allow admission to a hospital with a minimum of legal formality. The Draft Act Governing Hospitalization of the Mentally Ill, a model statute drawn up by a committee of psychiatrists and lawyers working under the auspices of

the National Institute of Mental Health, is representative of this trend. In most cases, it would permit hospitalization without judicial proceedings. Not only emergency cases, but any person, would be admissible to a hospital upon application of someone on his behalf, with certification by two "designated examiners" (physicians registered as specially qualified under standards fixed by state regulations).

The Draft Act would make a novel but sensible distinction between involuntary commitment and actual compulsion. Proceedings may be involuntary in the sense that they are initiated by someone other than the patient himself, and yet he may accept the judgment of the doctors and of his family, and upon certification may go to the hospital without protest. If he objects, however, a judicial hearing is required. But in emergency cases where there is danger that the patient will injure himself or others unless immediately restrained, he may be hospitalized upon the certification of the two designated examiners, endorsed by the head of the local health authority or by a judge.

Since 1951, the Draft Act has served as a model for new legislation in a number of states.

The British Mental Health Act of 1959 also goes far toward eliminating formal judicial proceedings even for compulsory hospitalization. Compulsory admission for observation or treatment can be ordered on the authority of two medical practitioners, one of whom must be specially experienced in the diagnosis or treatment of mental disorders.

Must a person be given notice of the commitment proceeding?

The person for whom commitment is sought must be notified, and is ordinarily required to be present at the hearing. To conduct a hearing that may result in a person being restrained of his liberty, without his being notified or allowed to appear and protect his interests, would violate constitutional prohibitions against depriving persons of "life, liberty, or property without due process of law." Serving legal papers on a seriously disordered person, however, can do him no good, and might only produce anxiety and confusion in his mind. A paranoid patient (a patient with delusions of persecution or grandeur), who is notified that court proceedings have been started for his commitment to the hospital, may try to flee, or to commit violence. A seriously depressed patient may be impelled to suicide. The law of some states therefore provides that if the court, upon a physician's certificate or otherwise, finds that service of notice on the patient would be harmful to him, the notice may instead be served on a close friend or relative.

Similarly, a few states permit the court, if it is of the opinion that the patient's presence at the hearing may be detrimental to his health, to waive the requirement that he be present. A patient, especially of the paranoid type, may already be suffering from feelings that people dislike him and from delusions of persecution. Compelling him to sit and hear his nearest and dearest relatives and his trusted physician testify to the facts concerning his mental condition and to his irrational behavior is likely to confirm his darkest suspicions. The results may be dangerous to these people as well as detrimental to the patient himself. Provisions allowing the court to dispense with the individual's presence at the hearing have been held constitutional, at least when he has been given actual notice of the hearing. Appearance by the person's attorney has been held sufficient to satisfy the right to appear and be heard.

Such abridgments of the right to notice and hearing have disturbed many lawyers, who value the right to notice and hearing as fundamental to justice, and especially as a safeguard against "railroading" sane persons into institutions. It is a precious heritage that permits us to insist that a man be served with notice of the pendency of any legal action in which his rights may be affected, and that he have opportunity to appear, to confront and cross-examine the witnesses against him, and to present any evidence he may have in his own behalf. But a proceeding to hospitalize an allegedly mentally ill person has some peculiar characteristics that distinguish it from an ordinary lawsuit. Such a person may be quite unable to avail himself of legal safeguards such as notice and hearing, and may only be harmed by them. A sane person can usually be left to decide for himself whether he needs hospital care for his physical ills. But the mental patient may not recognize that he is ill; he may rationalize all his symptoms and attribute the urgings of his family and physician as evidence of a plot against him. The problem is to devise procedures that will guard against arbitrariness or error, and yet avoid cumbersome and expensive red tape that serves no useful purpose but only subjects the sick to mental torture.

Is it possible for a sane person to be committed?

Errors may, of course, occur, either through mistaken diagnosis or through the intrigue of "friends" or relatives and unscrupulous owners of proprietary institutions. But the danger has been greatly exaggerated by writers of sensational fiction and allegedly true "exposés." Modern statutes have several safeguards against "railroading":

- 1) No one may be committed without certification by medical ex-

aminers. The doctor certifies that he has personally examined the patient; he does not merely take the relatives' word that the patient has been talking or acting peculiarly. A proper examination should include a physical examination and an interview out of the presence of others, so that the patient may talk freely and frankly.

2) Medical examiners who lend themselves to a fraudulent commitment are subject to suit for damages and in some states to fine and imprisonment.

3) If a person should be wrongly committed, the hospital authorities would presumably release him as soon as that fact became apparent. State mental hospitals, like most public institutions, are often overcrowded; they are not eager to keep anyone who may safely be released.

4) If the hospital authorities deliberately or negligently fail to recognize the person's sanity, he may always petition the court for release on writ of habeas corpus. Hospital authorities who prevent or interfere with a patient's efforts to petition a court for a writ, even when they act in good faith, may be personally liable for damages.

Are patients in state hospitals required to pay?

Most state hospital patients are admitted as indigents, but those able to pay are charged. Whether the person's estate, or his close relatives, can be charged with all or part of the cost of treatment can be more efficiently determined by the administrative officers of the hospital after admission than by the court at the hearing.

Does a person hospitalized for mental illness lose any civil rights?

In a few states, persons who have been hospitalized by court order are deemed incompetent to make contracts, execute deeds, etc. Most states today, however, recognize that hospitalization does not of itself constitute a determination of incompetency. Statutes in some states specifically preserve the patient's civil rights, including the rights to dispose of property, to make contracts, and to vote, except insofar as he may have been expressly adjudged incompetent to exercise such rights. Of course, if the person is actually incompetent to comprehend the significance of his act at time of execution, a will, contract, or deed executed by him may be set aside.

How may a committed patient be discharged?

The hospital superintendent is usually given the power to discharge patients, without having to get the consent of the committing

court. If the patient was admitted voluntarily, or for temporary or emergency care, the discharge is final. On the other hand, judicially committed patients are often released conditionally, or on temporary visits, in order to provide a period of readjustment to community living. In a few states the convalescent patient may be boarded out with a private family.

The writ of habeas corpus is available to any person who alleges that he is being restrained of his liberty illegally, and this includes anyone restrained in a mental hospital. Since even formal commitment is ordered to continue only so long as the person needs care and custody, it is always open to him to petition for the issuance of a writ on the ground that he is now sane and so entitled to release.

What is an emergency commitment?

At times the police and other agencies are called upon to take custody of mentally ill persons who are likely to injure themselves or others if not promptly restrained. Unless the law provides a procedure authorizing such persons to be taken to a hospital, they will necessarily have to be housed in a jail cell. Most states today allow temporary hospitalization in such situations. Typically these provisions call for one licensed physician to certify that the person named is mentally ill and because of such illness is likely to injure himself or others unless immediately restrained. Often the certification must be endorsed by a judge or court clerk. The hospital admitting a person under this procedure must promptly notify the patient's legal guardian, spouse, or next of kin and must have him examined within a short time, usually within 24 hours. If the examination shows he is not so mentally ill as to require hospitalization, he must be promptly released. If he is found to need hospital care, proceedings must be started for formal commitment.

Such a procedure is necessary not only for persons who appear to be violent, but also for vagrants and others who have no friends or relatives to sign an application but who obviously need care and custody.

Who should accompany the patient to the institution?

Instead of the patient's being taken to the hospital by a police officer, as was formerly common and as is still the practice in a few states, modern hospitalization statutes permit the family or friends to arrange for transportation by private means; or the statutes command the district health officer to arrange for the person's transportation to the hospital with suitable medical or nursing attendants. These statutes

also provide that, pending removal to the hospital, the person should not be detained in a jail, except in cases of extreme emergency, but instead should be detained in his own home, or in a licensed foster home or other suitable facility under conditions fixed by the district health officer. Most states require that a female patient be accompanied by her husband, a relative, or a female attendant.

A patient who is unwilling to go should not be taken to the hospital by trickery. He should not be told that he is "going for a little ride." It is better to tell him frankly that he is ill and needs hospital care, that the doctor and the judge have agreed that he must go to the hospital, and that he has no choice. Even the threat of force or actual force is better than deception. After he recovers, he will probably understand that force may have been necessary, but he is much less likely to forgive those who lied to him.

HUMOR AND MENTAL HEALTH

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What makes people laugh?

People laugh for many reasons. Besides the laughter at the comic, there is the laughter that is expressed to hide other feelings. People laugh to mask unhappiness or distress or to cover up social discomfort. They laugh when they want to deny the seriousness of a situation or when they want to hide the fact that they are angry. There is even the laughter of distress. People also laugh when they are suddenly relieved from fear. They laugh when they are pleasantly surprised. Children laugh in play just from happy spirits. From the moment when the infant first learns to smile and then to laugh at the mother, these expressions become increasingly social responses and ways of communicating emotionally with another person.

Can laughter be an expression of relief from anxiety?

Laughter may express sudden relief from anxiety. A number of philosophers have considered relief from distressing emotion as the primary function of laughter. This is often true but not always, for laughter is after all an expression of feeling too. The laughter that humor produces is an elemental expression of pleasure that is suddenly experienced. As Josh Billings put it, "Laffing is the sensation ov pheeling good all over, and showing it principally in one spot." Even this laughter, however, has many diverse and complex causes. People laugh at the awkwardness, ineptitude, and misfortunes of others. If these incompetences enable the spectator to feel superior or more skillful, he will laugh more freely. But people also laugh at the strange and different; they laugh at persons who appear unusual, whether in behavior, manner, speech, or dress. When people act like animals or automatons, it becomes a cause for laughter. According to the French philosopher, Henri Bergson, this is the primary feature of humor.

What is most striking about laughter is that it is a universal expres-

sion of emotion. All people of all ages know laughter. Charlie Chaplin was able to make the most primitive and remote people laugh hilariously by his comic antics without saying a word. Laughter itself transcends culture, era, and civilization. Many philosophers and writers have tried to explain laughter and humor on the basis of a single cause. None have been successful. To be able to explain fully the basis for laughter is to be able to formulate a comprehensive theory of behavior, for humor and laughter incorporate every aspect of psychology. It is interesting that the situations for laughter are so elementary, and yet so complex as to defy explanation. (See *Anxiety*)

What is the function of humor?

To provide a completely satisfactory explanation of the function of humor is to be able to explain humor itself. Perhaps at the most general level the basic function of humor is to give pleasure. Humor is one of man's easiest ways of obtaining pleasure. The difficulty lies in explaining how humor achieves this goal. But humor also has other functions. It can be used, for example, as a defense against experiencing displeasure or painful emotions.

According to Sigmund Freud, humor provides two different sources of pleasure: (1) so-called play pleasure, that is, the pleasure of playing, thinking, and acting like a child; (2) release pleasure, the release of inhibition of unacceptable wishes, particularly the wish to injure or to hurt.

With respect to the first source of pleasure, humor enables man to regress to a childish level as a relief from the serious business of living in the real world. By means of a variety of techniques like a play on words or punning, humor is able to evoke laughter as an expression of this sudden pleasure. In a sense then, humor is being foolish, or being able to think in a nonsensical way. To be humorous is to be playfully silly. Everybody recognizes how much humor depends upon childish ways of thinking and feeling. One can in humor suspend the rules of logic, reality, and reasonableness. Rules of language can be violated in the name of humor. This function of humor is thus seen to allow us to return to a time when thinking and acting involved a minimum of trouble and conflict and when rules and regulations frequently did not hold.

Humor also serves as an outlet for the expression of a variety of feelings that are inhibited and cannot be expressed openly and directly. By means of such techniques as satire and wit, man often can express

his hostile feelings with impunity. The laughter that humor evokes is the reassurance that the feelings expressed in the humor are recognized but accepted playfully. Thus, when one is angry with another person it is much easier and sometimes more effective to make a witty remark than to attack him directly. Similarly, a person who might never dare to talk about sex openly might not hesitate to tell an off-color joke.

Humor can also serve other purposes. By assuming a humorous attitude one can deny the seriousness of a threatening or a dangerous situation. A famous example of this use of humor is the remark made by Sergeant Daley in World War I when he called his men, pinned down in a shell hole, to a suicidal attack with a shout, "Come on, you bums, do you want to live forever?" This shout so aroused his men that they all jumped up and successfully made the attack in the face of murderous counterfire. (See *Emotions*)

What is a "sense of humor"?

A sense of humor has been defined as the ability to laugh at oneself or not to take oneself too seriously. However, when we talk about a person as having a sense of humor we mean it in two different ways. One is that the person can be humorous, that is, he can produce humor. The other is that a person particularly appreciates humor and laughs freely when other people are funny. In both meanings, to have a sense of humor implies a certain enduring character trait. Needless to say, it is one of the most desirable traits a person can have. In a recent study with college students and psychiatric patients, we found that the ratings of others and of the students and patients by themselves with regard to a sense of humor indicated that it was one of the most important personal assets and made an individual a very desirable companion. It was further found that people who are considered to have a good sense of humor were more distinctive as individuals and were more widely known than those who weren't rated so highly for this trait.

To have a sense of humor implies that one is able to assume a certain orientation or attitude toward oneself and toward the world. This attitude is often identified as the humorous attitude. It implies that the individual does not take the situation too seriously and is able to approach it with some detachment and playfulness. It suggests that the individual can accept the incongruous and the ridiculous without being disturbed by it. On the other hand, when a person is known to lack a sense of humor certain other undesirable characteristics are assumed to exist. That person is considered to be dull, uninteresting and un-

attractive, rigid, and lacking in zest and spontaneity. Possession of a sense of humor, in the sense of creating humor, is to have a rare talent. This talent is widely appreciated, and the success of our comedians attests to the rewards that go with it.

What are the different kinds of humor?

There are so many different kinds of humor and so many ways of categorizing them that no classification seems to do justice to the diversity. The simplest classification is that of the comedians who classify jokes according to the subject or theme. In this they seem to follow the pattern set by the English, who produced the earliest known joke books back in 1525. Indeed, joke books still maintain this pattern.

Another method of classifying humor is based on the medium of communication in which the humor is expressed. For example, in language there is a great variety of humor ranging from satire and comedy to puns and play on words. In pictures there are cartoons and caricatures. In acting there are the clowns and the mimes. There is still another method of classification, which is based on the techniques that are used to express the humor. The techniques of jokes and wisecracks, for example, are quite different from the techniques of satire.

Freud preferred to classify humor into three basic groups—wit, comic, and humor. Each of these groups gives pleasure in a different way. However, according to Freud, humor is divided into two primary types—the harmless or nontendentious, and the tendentious. The nontendentious form of humor achieves its goal of pleasure through the playful techniques, the nonsensical, the ridiculous, the incongruous, the macabre, and even through surprise. All these techniques represent the basic childish ways of thinking, feeling, and acting. The tendentious type, on the other hand, gratifies some unacceptable wish or intent like aggression. According to Freud, many forms of humor achieve their goal by means of both techniques together. The tendentious form is gratifying only when it is properly disguised by the nontendentious techniques. When the disguise is inadequate, humor does not gratify but actually may become disturbing because the wish is too evident. (See *Aggressions*)

Is extreme laughter associated with emotional disturbance, e.g., "the laughter of an idiot"?

Historically, laughter has often been associated with madness, particularly when it is extreme. Moreover, throughout the ages some wise men and clerics have cautioned against laughter as an evil. One reason

for associating laughter with emotional disturbance seems to be based upon the fact that it is not fully under voluntary control. Another reason is based on the fact that psychotics are seen to laugh without apparent cause, or inappropriately and hysterically. However, in some recent studies of the laughter of chronic schizophrenic patients, we found that what appeared to be inappropriate laughter was understandable in terms of the context in which it occurred. For example, psychotic patients very often laughed at the stupidities and ineptitudes or even accidents of others. Sometimes this laughter was delayed because the patient did not want to appear to be laughing at anybody. In other instances the patient laughed to avoid experiencing the intense anxiety that threatened to overcome him, or he laughed to deny the intense anger he felt. It is also true that in certain cases with specific or localized damage to parts of the brain, uncontrollable laughter, as well as crying, is observed. Almost any stimulus seems to be capable of evoking this hysterical laughter. These patients report that they are not experiencing any pleasure in their laughter and have no reason to laugh except that they cannot help themselves.

We sometimes speak of an attack of laughter. Laughter has been compared to an epileptic seizure and has often been called the "happy convulsion." "He who laughs is defenseless," is a common expression.

Laughter is very contagious. People who suddenly join a group that is laughing find it is difficult, if not impossible, to restrain their laughter even without knowledge of the cause of the group's laughter.

Because laughter is a form of emotional outburst, its control is often seen to be an essential aspect of good mental self-control. It is perhaps for this reason that among the upper social classes laughter is frowned upon. In a letter to his son, the Earl of Chesterfield wrote, "And I could hardly wish that you may often be seen to smile but never heard to laugh while you live." Many "cultured" groups condition their children to control the expression of any extreme emotion, including laughter. Thus, among these groups laughter is looked upon as a sign of lack of breeding or of poor training. On the other hand, among the lower social classes free and boisterous laughter is generally accepted and is regarded as an expression of good fellowship and friendliness. It is also true that among some national groups, particularly in the Orient, laughter is rarely heard and children are taught early to restrain the impulse to laugh. In short, the expression of laughter is recognized as an emotional outburst not fully under voluntary control, and therefore sometimes is regarded as a sign of a lack of self-restraint.

What is a "nervous" laugh? Is it a symptom of a nervous disorder?

A nervous laugh is one of the many varieties of laughter that usually does not express humor, but instead serves to cover up some disturbing emotion. Since laughter expresses pleasure and lightheartedness, individuals sometimes use this expressive mode to convey a lighthearted feeling when they are experiencing the opposite. They do not wish to exhibit the tension or discomfort they are experiencing, and so they laugh nervously as a camouflage. When laughter is used frequently or continually, it may even be classified as a nervous tic. The individual does it automatically. It is in this sense that the nervous laugh may be looked upon as a mild symptom of a state of tension or anxiety.

It must be emphasized that this so-called nervous laugh characterizes the laugh that is defensive, and is not a response to the comic. It is interesting, too, that the nervous laugh is never really successful because intuitively we recognize it as defensive and masking. It is so often applied to a situation that is not actually humorous that its very incongruity reveals it for what it is. Nonetheless, all of us at one time or another attempt to "laugh it off" when confronted with a situation whose seriousness we are reluctant to acknowledge or face. In many respects it is an admission of an inability to cope with a distressing situation; by laughing it off we hope to avoid it. The fact of the matter is that we can laugh off only those situations and problems with which we really can cope. (See *Mental Mechanisms*)

What is the purpose of "off-color" humor? Is an individual's preoccupation with it an indication of a problem?

Off-color humor serves several purposes. First, it serves as an outlet for interest in sexual matters. By sharing the laughter at off-color jokes, some persons are able to enjoy vicariously and momentarily the pleasures of sex. Off-color jokes also provide some persons, usually men, with the opportunity to laugh at the sexual inadequacies of others and thereby to reassure themselves of their own sexual potency.

Of course, the degree of smuttiness is controlled by matters of propriety, taste, and place. It is accepted behavior in some night clubs. In formal situations it is generally considered quite improper.

Off-color jokes also provide individuals with the opportunity to disparage the actions and feelings of those who violate the sexual taboos—the homosexual, the sex pervert, the adulterer—because very often people fear these feelings within themselves. By laughing at and ridiculing sex offenders, the individual is able to feel that he is superior to them

and not afraid of them. Again, the sharing of laughter becomes a form of self-reassurance.

However, when an individual becomes preoccupied with this form of humor he is obviously manifesting some symptoms of disturbance. Sex is likely to be a problem for such an individual, and he is perhaps maladjusted with respect to it. By seeking this form of outlet it is possible that the individual is not able to resolve his sexual problems in more direct and appropriate ways. For example, a man who is particularly frightened by women or is hostile toward them without being able to express it directly, may tell numerous off-color jokes at the expense of women and in this way try to reassure himself of his adequacy. Thus, an individual who is unable to fulfill or gratify his sexual desires may substitute talking about sex or joking about it. His vicarious gratification instead of complementing his normal pleasure may stand completely in its stead. In such instances, the individual may reveal the basic difficulty in his relationship with women. (See *Psychosexual Development in Man*)

What is responsible for "sick" humor? Is it a sign of the times?

We must first clarify what we mean by "sick" humor. Generally, sick humor refers to the kind of humor that not only pokes fun at the most sacred institutions and revered persons, but does so with a violence that is shocking. For example, many sick jokes are addressed to the murder and dismemberment of parents, grandparents, and siblings. The reaction to this form of humor is often one of shock, and the laughter that it may produce includes discomfort and embarrassment. Sick humor often demonstrates the so-called double-edged sword of humor in the sense that there is a very fine line between its pleasure-giving qualities and its ability to arouse discomfort.

Sick humor also illustrates the psychoanalytic notion that all humor deals with unexpressible or inhibited wishes, and that in the joke these wishes are disguised and therefore made acceptable. In sick humor, however, the disguise is too thin to be acceptable. The aggression it often exhibits is too archaic and too violent. To the mature person sick humor is very often frightening because if the individual has these feelings of aggression (as most people have), they are so profoundly repressed and covered up that they are not accessible to awareness, and any possibility of their expression is frightening to contemplate. Thus, to joke about killing one's mother is difficult to appreciate as humor, especially if it is done in the macabre ways expressed in sick humor.

In some recent studies of primitive people it was found that certain clowning rituals contained extremely depraved and debauched behavior that was observed and laughed at. The clowns did repulsive and disgusting things that, if observed out of context or if performed anywhere except in the rituals, would clearly have been regarded as very pathological. However, during the course of the rituals, this kind of clowning met with great laughter, hilarity, and approval, even among the most inhibited and correct Indian tribes.

The situations in which sick humor prevails in our own society often reflect similar attitudes. Sick humor seems to be most appreciated by adolescents, who by and large are in a state of rebellion against customs and traditions. For the adolescent, the sick joke is another way of attacking authority and breaking with parental control. Many of these adolescents debunk filial, sibling, and even family relationships and affection. The institution of the home is attacked as sentimental, archaic, and useless. In our present turbulent times, where many of our values are in the process of major change, sick humor reflects the violence with which adolescents react to the old traditional ways.

In a sense, sick humor is a sign of the times, and each era has its own forms of sick humor. For example, throughout many periods of history much laughter has been directed at the disabled, the maimed, and the defective. Now, we regard this as inappropriate. For these reasons, throughout the ages, many philosophers have felt that laughter is often an expression of arrogance and insensitivity to the suffering of others. Nevertheless, there are examples of sick humor that a great many people think are funny. It is perhaps because they can assume the humorous attitude that they are able to consider these as "only a joke." (See *Adolescence*)

Is humor usually based on someone else's pain or discomfort?

There are some theories that are based on the assumption that humor is made at the expense of others. Such theories maintain that when we laugh, we laugh at someone else's pain or discomfort. While it would certainly be false to say that the pain and discomfort of others are never occasions for humor, it is an exaggeration to claim that they are the only occasions. There are many forms of humor and sources of laughter that do not involve this element at all. When we act silly or speak nonsense, we do not laugh at somebody else's discomfort. However, when people laugh at a clown or at someone who trips ineptly over a step, it is certainly true that they are laughing at the other

person's expense. But the primary prerequisite for such laughter is that the discomfort of the other is not so great as to be really painful or distressing.

Aristotle maintained that humor can arise in the appreciation of some minor flaw in another person. He claimed that one laughs at the ugly and distorted but only when they do not evoke pain. Plato emphasized the fact that we laugh at the affliction of others, not because it is painful, but because we feel superior. This superiority theory has considerable credibility, and has been widely accepted. Thomas Hobbes based his theory of humor upon this notion. In one of his most commonly quoted passages he stated, "I may therefore conclude, that the passion of laughter is nothing else but sudden glory arising from some sudden conception of some eminency in ourselves, by comparison with the infirmity of others, or with our own formerly; for men laugh at the follies of themselves past when they come suddenly to remembrance, except they bring with them any present dishonor."

Why are some individuals unable to see the humor in a situation or cartoon that others find humorous? Can the things a person laughs at be a clue to his personality?

Every individual has had the experience of finding himself unable to appreciate a joke or some form of humor that other people regard as quite funny. This fact demonstrates the double-edged character of humor in the sense that there is a fine line between its pleasure-giving qualities and its disturbing quality. Actually, the kinds of humor a person appreciates often provide basic clues to the kind of person he is. A number of studies have demonstrated that one can make important inferences about an individual by studying the kinds of humor he enjoys or finds disturbing. Some people do not think that jokes about mothers-in-law or about religion are funny. They take these matters much too seriously to see anything funny in them. On the other hand, some people enjoy very hostile or very aggressive kinds of humor directed perhaps at some particular institution like the government or the police, etc. In most instances these people have some dislike for these institutions and do not feel altogether free to say so or to express it in any other way. These studies have shown how deeply humor taps the human personality.

In a recent study it was found that even highly intelligent and sophisticated individuals not only have been unable to appreciate some relatively simple joke or cartoon, but have also failed to understand it.

Further investigation revealed that in many instances these failures reflected a hidden wish not to get the point of the humor because it would turn out to be too disturbing. Due to some error in perception these individuals failed to comprehend the joke. One typical example was a woman having marital trouble who failed to understand a simple cartoon dealing with a marriage problem. By contrast, a prudish person may fully comprehend jokes about sex, but these may cause him to feel embarrassment or disgust.

Is it true that comedians are often unhappy people? If so, how does this bear on their becoming comedians?

It is true that some comedians have been known to be depressed or unhappy people. The fact that other creative artists may also be depressed individuals does not seem to be so impressive as it is with comedians. This observation is probably related to the image we have of the comedian as a person who must look upon the world through rose-colored glasses, always laughing and joking. The truth of the matter is that if a person sees the world only this way, he is probably covering up deeper feelings of unhappiness or is unwilling to look at the world realistically. However, it is understandable that the ability to make other people laugh provides some comedians with a way of dealing with their own inner dissatisfactions and needs. Very often people make clowns of themselves and strenuously try to make other people laugh because this is their way not only of bringing attention to themselves, but also of expressing their own resentment and self-hatred in acceptable fashion.

The ability to make others laugh is the comedian's or comic's way of winning appreciation and perhaps love; without the laughter he would feel unwanted and lost. Thus, these artists very often intend to show their power over others by creating a situation in which they can evoke laughter at someone else so they can be laughed *with* and not *at*. They provide, through their jokes and wisecracks, pictures and attitudes for their audiences to laugh at. The acclaim and the rewards they receive are further confirmation of their success in winning the recognition they seek.

The comedian's laughter-evoking ability is his way of achieving some social identity that is meaningful. These dynamics need not be pathological as long as they are well within normal limits. They become pathological only if they become the sole motivating force through which the individual seeks to relate to others. When the clown-

ing or wisecracking becomes the person's only way of relating to others, it suggests that he cannot establish mature relationships. Using his comic ability is a way of relieving his inner distress.

Is a sense of humor an index of good mental health?

It seems paradoxical that laughter can be regarded as a sign of madness and also as a sign of good mental health. The paradox is resolved if one understands the reasons for the laughter. The reason why the possession of a good sense of humor can be an important index of good mental health is that it implies certain abilities and attitudes. Essentially, a sense of humor implies that the individual is able to assume a playful, "in fun" attitude toward the world. The person is able to detach himself from the seriousness and the cares of reality, and joke about it or deal with it in a lighthearted way. This attitude means that the individual is not frightened by the situation, but is master of it, and suggests that he possesses a sense of inner strength. This is a fact that Freud so frequently emphasized. It means that the individual is able to relax his defenses against threat. He can tolerate anxiety and frustration for the moment.

A sense of humor implies also that an individual is able to laugh at himself and not to take himself too seriously, that he can take a benevolent and friendly attitude toward his impulses, his wishes, and his infirmities. The extreme moralistic, ascetic puritan or prude is incapable of taking a friendly look at himself. Above all, a sense of humor often means the freedom to enjoy the pleasure of self-indulgence. Furthermore, to be able to laugh with others indicates that the individual can relate to others in a friendly, intimate fashion. He is capable of sharing feelings. This is what it means to be free to laugh.

When one can genuinely laugh it off, one is not frightened by the consequences one may feel. The best example is in what is called "gallows" humor. Freud cited this instance: "A rogue who was being led out to execution on a Monday remarked, 'Well, this week is beginning nicely.'" Donald Ogden Stewart said, "My comic hero would be a man who overcame death, not by religion, but by humor, and who could laugh at the electric chair as he walked to it."

The playful or humorous attitude essential to a sense of humor requires above all else the ability to allow oneself to be childlike again, to enjoy nonsense and the ridiculous. It means the relaxation, for the moment, of all rational and reality controls. Evidence that this requires considerable strength of ego has been indicated in studies showing that

psychiatric patients by and large are incapable of enjoying humor to the same degree as nonpsychiatric individuals.

Are there temperamental differences between people who never laugh and people who react as though everything were funny?

There are more than mere temperamental differences between the humorless person and the person who is always laughing. The humorless person is obviously one who cannot allow himself to be foolish or playful. His guard is always up, he must maintain his self-control lest in losing even a little control he might lose all. It is true that the person who cannot express humor is likely to be unable to express other emotions that are less acceptable. He is often rigid, prudish, and critical—fundamentally an unhappy person who is unable to enjoy moments of relaxation or of play. He must drive himself constantly, to do his duty, maintain his responsibility, and see that others do the same. He is critical of anyone who does anything else. On the other hand, the person who is always laughing and joking may be a person who is struggling vainly to deny any experience of unhappiness or distress. He is constantly seeking ways of dispelling even the slightest feeling of gloom or despair. He may tend to be a rather superficial person because he cannot allow himself to feel very deeply. Laughter has become his way of defending himself against unhappy feelings or against unhappy social discomforts that everyone experiences. The constantly laughing person uses laughter as a defense rather than as an expression of pleasure. No one can laugh all the time, unless he must maintain a constant state of detachment and uninvolvedness in the serious business of life.

Does humor have a therapeutic value?

Humor may have therapeutic effects upon the individual but that is not necessarily always the case. After all, humor usually has only a momentary pleasurable effect. It cannot overcome strong distressful emotions nor can it be effective if the individual is incapable for one reason or another of assuming a humorous attitude. Nonetheless, humor can have lasting positive effects. As Freud and Theodor Reik have pointed out, in humor there are profound inner truths that in many respects are comparable to the profound insights gained in the psychoanalytic process.

Very often in psychotherapy certain insights and basic relationships can be brought home most effectively through humor. An example is

the guilt-ridden patient who was concerned about his responsibility for his wife's constant nagging and complaining. On one occasion he reported his wife's bitter accusations that he neglected her because he frequently worked late in the evening. He reported to his therapist that perhaps she was right and that he chose to work in order to avoid her nagging. The therapist commented that it reminded him of a story of a young preacher in a backwoods fundamentalist parish who had to ski to church one Sunday morning because the roads were impassably snowbound. For this he was called before the bar of the presbytery for breaking the Sabbath. He defended himself by saying that this was the only way he could get to church that day. An elder replied, "Young man, there is just one question. Did ye or did ye not enjoy the skiing?" Very often in therapy, humor can be an extremely effective instrument to help a patient accept an interpretation that would otherwise make him too anxious.

Another excellent example of the therapeutic role of humor is illustrated by the remarkable eruption of joking that took place during the blitz over England in World War II. People were reported to have gone about their various assignments cracking jokes and otherwise showing high spirits. The English are not noted for this kind of humorous attitude, nor is this behavior what one would expect at a time of great peril. But the joking served as a powerful unifying bond and promoted an extremely high level of morale, in this way helping the people to cope with a terrifying situation.

Is humor an important social force?

The role and impact of humor varies from culture to culture, but there is little doubt that it can play a most significant part in society. It functions primarily as an informal, though sometimes also as a formal, way of controlling, informing, and influencing the behavior of the group. Political cartoons, dramatic satire, and comedy all informally reflect the ways and foibles of a society. They may have considerable effect in making the public aware of the deficiencies and extravagances prevailing in the social order and thereby in changing the customs and values of society. David Worcester stated in his book, *The Art of Satire*, that "the intellectual critical spirit that attacks pretense and acts as the watchdog of society is the comic spirit."

A famous example of humor's effective influence on the social scene is the series of cartoons (1870) in which Thomas Nast so mercilessly attacked Tammany Hall and the "Tweed Ring" that he is credited with

the downfall and conviction of William Tweed and the destruction of Tammany's power.

Humor is also commonly recognized as an effective way for a group or a culture to express any of its concerns and conflicts. Joking about these matters helps to alleviate the anxiety over these social threats. By sharing laughter the individuals are strengthened in their feelings of being able to master these dangers; there is an increased cohesiveness among the members and this reinforces feelings of inner strength. In such a way popular humor can intensify the group's mutual identification and provide it with a means for neutralizing some of the interpersonal tensions that ordinarily prevail.

Thus we see that humor may help to preserve order in society and contribute to its smooth operation, and that it also serves to initiate change and social improvement.

HYPNOSIS

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What is hypnosis?

No satisfactory definition has as yet been formulated. Both the British Medical Association and the American Medical Association have defined hypnosis as a temporary condition of altered attention, induced in the subject (or patient) by the hypnotist (the operator or physician), and within which a variety of phenomena may appear spontaneously or manifest themselves in response to verbal or other stimuli. This definition reduces itself to a description of the various phenomena that may be elicited when a person is in a hypnotized state, including alterations in memory and in consciousness, increased susceptibility to suggestion, anesthesia, paralyses, muscle rigidity, vasomotor changes, etc. Any single one of these phenomena may be present when a patient is hypnotized, or any combination of them, or none at all. Increased suggestibility, therefore, is no longer considered an explanation of, or a necessary concomitant to, hypnosis.

Can anybody be hypnotized?

The answer depends on how we define hypnosis. Between 1951 and 1959, many articles in technical journals claimed that 100 per cent of the population can be hypnotized, but these articles discussed hypnosis in quite general terms.

Approximately 25 per cent of the general unselected and unscreened population—figures in the literature vary from 15 to 25 per cent—can under appropriate conditions manifest what serious workers in the field would label as hypnotic phenomena.

Can women be more easily hypnotized than men?

No. The sex of the subject is not a factor so far as hypnotizability is concerned. Neither is the sex of the hypnotist.

What makes for hypnotizability?

No one knows. There are many theories. Almost every aspect of the subject is controversial.

Can subjects be hypnotized against their will?

Yes. Some subjects can be hypnotized—and to deep hypnotic states—with or without their knowledge, and with or without their consent. They can be hypnotized standing up, seated on a chair, or lying on a bed or a couch. And on trance induction some subjects not only can, but at times spontaneously do, develop self-destructive or antisocial behavior, or both.

Can a trance be faked?

Yes. In rigorously controlled experimental studies at Harvard, experts were at times unable to distinguish between hypnotized subjects and nonhypnotized controls simulating hypnosis, nor could some nonhypnotized subjects be distinguished from hypnotized controls acting as though they had not been hypnotized.

What is posthypnotic suggestion? How does it work?

Some hypnotized subjects can be given suggestions or commands to carry out specific acts after termination of the hypnotic trance. This is called posthypnotic suggestion. There are a number of theories about how and why this occurs, but the current, most likely explanation of the phenomenon is that a new hypnotic trance is precipitated when the posthypnotic suggestion becomes effective.

What is self-hypnosis? Autohypnosis?

They are the same thing. It may—or may not—be dangerous to the individual making use of it. Large numbers of patients with borderline psychotic reactions are requesting this. No matter how harmless their reasons seem to be, they nevertheless require cautious evaluation. Some patients who previously were hypnotized for dental work, for childbirth, or for other reasons, have been given posthypnotic suggestions by their hypnotists to hypnotize themselves whenever they have headaches, dysmenorrhea, or other pains and aches so that on autohypnotic levels they can by suggestion dispel them. Self-hypnosis for some of these patients, nevertheless, had rather dangerous sequelae, for they utilized it to get farther and farther away from the real world, to sink deeper and deeper into fantasy formation, and to promote the onset of borderline, or more than borderline, psychotic states.

The individual who hypnotizes himself may feel that he does it for constructive purposes, but he may nevertheless use it self-destructively,

even, for example, if he thinks he wants it only in order to be able to concentrate more effectively on his academic studies.

If suggestions for self-hypnosis are under consideration, therefore, it is always advisable to determine first of all how the subject will make use of autohypnotic trance states. In the writer's opinion suggestions for self-hypnosis or autohypnosis may otherwise be the equivalent of giving a patient a permanently refillable prescription for narcotics.

Who was Mesmer?

Franz Mesmer was an Austrian physician who was the father of hypnotism. Present-day scientific studies of hypnosis started with his study of what he named "animal magnetism."

What attributes and what powers did Mesmer claim for hypnosis?

Mesmer claimed in 1779 that hypnosis "can cure nervous disorders directly and other disorders indirectly," and that by its use physicians "will be able to determine the origin, nature and progress of even the most complicated illnesses" and thereby "prevent them from advancing and succeed in curing them without exposing the patient to dangerous effects or unfortunate consequences."

He added that the mental condition he used, which his contemporaries called "mesmerism" or "magnetism" and which we now term "hypnosis," would furnish fresh explanations about the nature of fire and light, of gravity, magnetism, and electricity. He claimed that his theory would enable physicians to safeguard each individual from the maladies to which he would otherwise be subject.

Did Mesmer make extravagant claims?

Yes. He claimed that with so-called magnetic wands he could make the sick healthy. Both he and his followers, the mesmerists or magnetizers, charged huge fees and attracted large crowds. One mesmerist sold George Washington a set of metal pieces that were said to have magnetic or hypnotic qualities that could cure all pain. A student who failed in his medical studies at Edinburgh opened a "temple of health" in London with a celestial magnetico-electrical bed, adorned with magnets and set on forty pillars of glass, for the use of which he charged one hundred pounds to effect sexual cures.

Was Mesmer discredited?

In 1784, a special commission of physicians and scientists was appointed to investigate Mesmer's claims. Benjamin Franklin, the

American Ambassador to France, served on it. So did Antoine Lavoisier, the discoverer of oxygen and the father of modern chemistry. They practically branded Mesmer a charlatan, for they realized that although hypnosis had valid uses, it could be harmful.

Was hypnosis used before the time of Mesmer?

Yes. Some authorities feel that hypnosis is allied with and perhaps the same as religious hallucinatory experience. This may or may not be so. If the relationship exists, it may have characterized the "temple sleep" of ancient Egypt, Asia Minor, and Greece, which was originally connected with the worship of a beneficent maternal deity. It may perhaps be that sick individuals wishing to be helped were hypnotized. It may also be that at times temple priests went into self-induced hypnotic states. What seems to have been self-hypnosis continued well into the Christian era with the monks of Mount Athos (Greece) who may have used it in order to experience what they termed the "uncreated light of Christ."

However, with the advent of Christianity, pagan survivals in some areas were identified even with Satanism. This held true for phenomena now thought to be hypnotic.

Why was hypnotism thought by many to be one of the satanic arts?

Not because at times it was thought that even murder or rape could be committed under its influence—although this has been alleged—but because some paranoid and egomaniacal hypnotists elevated themselves, and were elevated by some of their hypnotized subjects, almost to the rank of a god. To the Christian, therefore, this became a violation of the First Commandment. Hypnotism as a result rapidly became associated with witchcraft, Satanism, and black magic.

How was hypnosis separated from its association with sorcery?

Because of Mesmer's work, hypnosis began to be studied medically. The Marquis de Puységur described somnambulism. James Braid evaluated hypnosis in psychological terms. The studies of hypnosis by both Ambroise Liebeault and Hippolyte Bernheim influenced Sigmund Freud, who as a result of his work in hypnosis with Josef Breuer was led to a consideration of free association and psychoanalysis. With the impetus given to the use of hypnosis in the treatment of combat induced casualties in World Wars I and II, hypnosis has now become an acceptable research instrument and has been incorporated into the medical, including the psychiatric, armamentarium.

Mechanical gadgets and electronic fixation objects are sometimes used to induce hypnosis. How necessary are these?

In most cases the only apparatus needed is the voice of the hypnotist.

Fixation objects for hypnotic induction are widely advertised. They sell at prices ranging from a few cents to a few hundred dollars each, depending on how elaborate they are and how much science fiction and science fantasy—in the form of misstatements about brain wave tracings, extrasensory perception, and what not—are emphasized in their promotional material. These objects, it should be stressed, are seldom if ever needed.

How are hypnotic trance states induced?

For the most part, through two different groups of techniques, the classical and the radical, although a number of intermediate and variant techniques have also been described.

The more usual classical trance induction techniques make use of eyelid closure. When the more radical techniques are utilized, the eyes may never close even during the first induction process.

What are the classical trance induction techniques?

These are the techniques that for the most part make use of eyelid closure, which has been popular ever since it was first described in the 1840's by Braid (1795–1860).

Most present-day hypnotists tell their subjects to focus their gaze on a spot on the wall or the ceiling; on a finger, an eye, or a pen; or on some glittering object. Direct authoritative commands or permissive suggestions are then monotonously and repetitively given to the subject to breathe deeply but comfortably, be relaxed, close his eyes or have his eyes closed, and feel sleepy or fall asleep. It may be added as a post-hypnotic suggestion that he will—or will not—remember, forget, or misremember whatever he does, says, or feels while hypnotized. This suggestion may—or may not—be posthypnotically effective. It often is.

How many minutes does it take to learn to hypnotize?

Any reasonably intelligent adult can master the general principles involved in the more classical induction techniques within fifteen to thirty minutes at the most.

Can subjects, when hypnotized, transcend their nonhypnotic physical or intellectual abilities?

No, although there are numerous reports to this effect in the literature.

The Harvard group under Martin Orne has shown that when hypnotized subjects apparently transcend their more usual nonhypnotic physical abilities, this means only that their motivation for such performance has increased. Their motivation can be equally increased, however, by nonhypnotic means. During a series of ingenious experiments on motivation, some subjects when not hypnotized transcended their abilities that apparently had been increased while they were hypnotized.

Has there at times been conscious dishonesty in statements about hypnosis cures?

Yes, occasionally there has been.

Melodramatic "cures" often are publicized, but the patients' subsequent histories, and accounts of unsuccessful treatments, may not be. We know of cases where athletes have been hypnotized to increase performance, only to perform on a lower level than previously, but these have not been publicized. On the other hand, a player (hypnotized by the same hypnotist) who performed well, received considerable publicity.

If a subject is put under a physical strain while hypnotized, will he feel the strain afterward?

He may feel the strain. He may in fact suffer serious physical harm. Boxers and members of swimming, baseball, and basketball teams, have been hypnotized in order to increase athletic performance. Because of the possible hazards involved, the Committee on the Medical Aspects of Sports and the Council on Mental Health of the American Medical Association on July 1, 1960, issued a *Joint Statement on the Use of Hypnosis in Athletics* condemning this practice.

According to this statement, an athlete while hypnotized or as a result of posthypnotic suggestion may be encouraged to attempt to go beyond the limits of his physical ability and as a result may experience a state of harmful exhaustion. He may in addition, because of suggestions given him while hypnotized, be so intent on performance that he lays himself open to injury, particularly in contact sports, through posthypnotic disregard of the safety factors he has learned to observe during competition.

The report stresses that during experimental hypnosis research studies on physical performance, bodily impairment (discernible only by careful medical examination) may be aggravated, with possible irrevocable injury to the subject. The American Medical Association (A.M.A.) therefore states that the athlete should be taught to rely on his own resources to attain optimal performance, that hypnosis should not be employed for the purpose of influencing such performance or with the objective of winning or losing an athletic contest, and that in research whenever hypnotic techniques are utilized with athletes, competent medical (including psychiatric) consultation and supervision is mandatory.

Why did the A.M.A. in 1958 express itself as unequivocally opposed to the use of hypnosis for entertainment purposes?

Because adverse reactions had developed in individuals hypnotized for entertainment purposes. A number of examples can be given.

An eighteen-year-old volunteer during a group hypnosis became agitated when it was suggested that he hallucinate seeing his aged grandmother. He later relapsed twice into the trance state and wept. Psychiatric examination revealed that the boy had been markedly dependent on this grandmother after the death of his parents. The stage hypnotist had unwittingly set up an area of insecurity that was so pronounced that it necessitated psychiatric hospitalization.

A twenty-two-year-old male was hypnotized by a stage magician who had him lie cataleptically on two chairs, his head resting on one and his heels on the other, while members of the audience sat on him. The following day, he was taken to a psychiatrist, mute and with waxy flexibility. Repeated hypnoses were of no effect. Shock treatment was started one week later. After the third treatment, he was no longer mute. He ultimately made a complete recovery, but had no remembrance of the experience.

After two girls had been hypnotized in London by a New York hypnotist, they developed severe adverse reactions that lasted for months. The resultant furor with all its publicity led to the passage of the British Hypnotism Act of August 1952, effective April 1953.

Why does the British Broadcasting Corporation no longer televise programs that show persons being hypnotized?

Because after experimenting with a closed-circuit telecast during which hypnotic induction procedures were televised, it found that in-

dividual members of its nonstudio audience were developing potentially harmful hypnotic trance states.

Can a hypnotized person's sense of time be manipulated?

Yes. There can be time regression, time progression, and time distortion. Subjects, if regressed, travel backward in time. They may, however, travel forward instead, which is time progression. Or there may be a change in subjective time as contrasted with objective or world time, so that the individual within a few seconds or minutes seems to live hours, days, months, or years. His time sense is speeded up. On the other hand, he may live not in accelerated, but in slowed-down, time. All three types of time manipulation require further study.

Can subjects under hypnosis recall or re-experience events that happened earlier in their lives?

Yes. Some subjects spontaneously or on hypnotic suggestion emotionally "re-live" very traumatic events of their past lives. Former soldiers may go back to a battle situation and be in the midst of combat, experiencing a hallucination of it through sight, sound, touch, and smell.

Some subjects may reenact childhood events—a fight with a friend in a school yard; a trip to the zoo with a brother, sister, or father; or a birthday party. They may at times function concurrently on two separate levels of consciousness. One woman felt that she was in a taxicab on the way to a hospital while giving birth to her eldest son some ten years previously, although at the same time she knew she was in the psychiatrist's office and was addressing him by name while telling him about this. Other patients, when they regress this way, seem to blot out all memory of subsequent events, are unaware of the fact that they are in the psychiatrist's office, and experience whatever they seem to be reliving in all its original intensity.

A word of caution needs emphasis here. What is enacted, described, or "relived" on hypnotic levels does not necessarily have to be factual. It may be a product of fantasy.

Is it dangerous to regress subjects through hypnotic intensification of emotion?

Yes, it is dangerous. The subject may be told that, as his hypnotist counts to ten or to any number, whatever he is feeling, whatever his

main emotion is, will grow stronger and stronger with every second that passes, with every breath he takes, until he feels it fully and completely. He may then spontaneously or on signal regress to another period, earlier in his life, when he had felt exactly the same way.

A smiling and apparently even happy patient may be dissimulating a depression or be evidencing what technically is termed "reaction formation." In other words, we sometimes feel happy—and are convinced that we feel happy—in order to keep from being sad. If this particular hypnotic technique is utilized with an essentially depressed patient, even though he is smiling and seems happy, his underlying depression may be intensified even to the point of possible—or actual—suicide. The psychiatrist is qualified by training and background to recognize underlying depressive material of this type, although even he may sometimes fail to find it.

Is it possible for a patient under hypnosis to recall events as far back as the incidents of his birth?

No, although this has been stated over and over again in print. Whenever techniques of the type summarized above are utilized, apparent regression to previous periods of one's life can readily be effected. Some individuals may regress even to infancy. Sometimes patients may regress still further. Psychiatrists not infrequently see patients who even when not hypnotized have birth fantasies. One patient, for instance, immediately after entering the office for the consultation, lay down on the floor, kicked off her shoes, gave vent to a series of grunting wails, and when questioned explained that she was now being born. This patient was not hypnotized. She was schizophrenic, and "closed ward" psychiatric hospitalization was recommended. On the other hand, some nonschizophrenic patients, when hypnotized, have enacted the same birth fantasy. This does not mean that they actually re-experienced passing through the birth canal. It means that at that particular time they thought they were. These patients were able to talk. Newborn infants cannot.

No one, who (on behavioral levels) has regressed to a period predating speech, can describe in words what he is doing or sensing. The body may remember and engage in actions or show sensory phenomena that may or may not be appropriate, but if the individual actually regresses on motor behavioral levels to a period predating his ability to talk, he cannot on verbal levels discuss this experience.

In hypnosis can a person re-experience being back in the womb?

Some individuals, immediately on hypnotic induction, are convinced that they are inside the womb. This the psychiatrist treats as fantasy, bringing it up for consideration during therapy in exactly the same way he would if the patient had developed similar fantasies on nonhypnotic levels.

Can subjects, when hypnotized, go farther back through time until they "re-live" events in previous existences?

No, but they may seem to. Some persons have returned—this is their word—to pre-Christian Rome, to pre-Christian Greece, and to pre-Mosaic Israel. In each case, when such material is taken up psychotherapeutically, these fantasies appear in their true light, and the "evidence" supporting reincarnation collapses.

Fantasies of a previous existence can readily be evoked, and to the naïve and untrained observer, no matter how conscientious he may be, they may seem not fantasy, but fact. The psychiatrist frequently sees this phenomenon in his practice. Napoleons, Caesars, Aristotles, and Christs he usually commits for treatment to the disturbed wards of psychiatric hospitals. Yet nonpsychotic subjects when hypnotized may develop the same fantasies, just as they do when dreaming.

Some subjects, on hypnotic induction, may spontaneously regress to prehistoric eras, occasionally evidencing even primate-like behavior. One patient with headaches became a dinosaur. He was, of course, emotionally very sick—in dinosaur form he hoped to be as frightening to people as he, in his daily present-world life, was frightened by them.

Do such patients actually travel back through time hypnotically?

No. None of these patients in actuality, of course, had traveled back through time. In fantasy, however, all felt they had. Such fantasies, characterized by enacting and confabulation, should be handled psychotherapeutically—but by competent and well-trained personnel only—and in exactly the same way as they would handle any other type of fantasy.

Is hypnosis a technique for calling forth fantasy?

It seems to be. Whatever else (with further research) the hypnotic interpersonal relationship may turn out to be, hypnosis can be defined as a fantasy-evoking technique in which one person (the subject or

patient), on the basis of his experiential background and with more ready access to his "preconscious" (thoughts not in immediate awareness, but which at certain times may come into it), may think, feel, experience, react, fantasy, melodramatize, or on motor behavioral levels even enact whatever he knows or fantasies another person (the hypnotist, operator, or doctor) wishes him to. Or, if he is negativistic, he may do the very opposite. He may, while hypnotized, project his own impulses, desires, and fantasies on his hypnotist. Actions and reactions of subject and hypnotist during the induction process and afterward may intermesh.

The subject as a result may respond (a) to the hypnotist's direct verbal suggestions, (b) to the hypnotist's nonverbally articulated but nevertheless fairly obvious and well-perceived preconscious desires, or (c) to the hypnotist's unconscious fantasies. Emotional regression—hypnosis always involves this—by the subject may be independent of, may directly reflect, or may be paralleled by, emotional regression on the part of the hypnotist.

Is hypnosis a medical specialty?

No. Hypnosis is a medical technique, not a medical specialty. There is no bona fide hypnosis specialty board recognized by the A.M.A.

Is hypnosis a potent medical technique?

Yes. But hypnosis for symptom relief is palliative, not curative. Hypnotic techniques, although they do not of themselves constitute treatment, may by mere verbal suggestion make it possible with selected patients (a) to control physical and emotional pain, (b) to allay anxiety and apprehension, and (c) to cause even incapacitating symptoms to disappear.

How successful has hypnotic intervention been in medical practice?

Results in medical practice can sometimes be exceedingly dramatic. With selected patients, pain can be partially or completely abolished. Hypnosis has been used for hysterectomy and for Caesarean delivery. It has been utilized as a partial anesthetic during a lung operation. It has stopped the headache of a brain tumor. It has put an end to one patient's compulsive chain smoking; kept another patient from grinding his teeth while asleep; and has made it possible for a 320-pound woman to lose 60 pounds within a few months.

Fractures may be set under hypnosis. Patients can be hypnotized for

minor surgery or for childbirth. Patients with cardiovascular disease may be helped temporarily to decrease their tobacco intake or, but more rarely, to cease smoking for a while. Pain and discomfort, though organically determined, may be influenced to disappear temporarily.

But in some cases, the use of hypnosis has resulted in dangerous complications.

What is the physician's attitude toward hypnosis?

Physicians who use hypnosis do not consider themselves hypnotists. For them hypnosis is one technique—but only one—among various techniques at their disposal. They are physicians who, when it seems indicated, may with specific patients and for very specific treatment goals, make use of hypnotic techniques. They neither oversimplify nor overdramatize what they are doing.

Under what circumstances do physicians hypnotize patients?

Physicians who hypnotize patients according to the minimal standards set by the A.M.A. for the use of this technique in medical practice, treat patients on hypnotic levels only for goals and only with techniques that would be within the areas of their professional competence if they were treating these same patients on nonhypnotic levels. They make use of hypnotic techniques on a highly selective basis and only after making an adequate physical and mental examination of their patient.

Does the Catholic Church oppose the use of hypnosis for medical purposes?

It does not. Nor does it oppose the use of hypnosis in psychological research. Hypnosis has been used in the delivery of babies in Catholic hospitals, and a series of lectures on hypnosis in medicine was offered in 1959 on a postgraduate basis to physicians in a Catholic medical school. According to Pope Pius XII in 1956, however, hypnosis is not to be used by ecclesiastics except with special permission; nor is it to be considered a plaything by the layman.

Have there been hypnotic cures of symptoms as a result of which patients have suffered irreparable harm?

Yes. This has occurred with a number of patients whose underlying psychopathology remained untreated. To illustrate, a business executive's wife had a hypnotist cure her compulsive chain smoking. She

instead became a compulsive overeater, gained forty pounds, and then asked another hypnotist to cure her obesity. He restored her slim figure through hypnotic suggestion, and she then became a compulsive drinker. Within a few months she was so often under the influence of alcohol that she wished to get a hypnotic cure for her compulsive drinking. She requested this of a psychiatrist, who refused to proceed with her in this way. He thought further hypnotic suggestion of the kind already used might result in suicide or drug addiction. She should not have been hypnotized in the first place.

A taxi driver gnashed his teeth in his sleep. His dentist cured this by hypnosis. Two nights later, during a nightmare from which he could not at first be awakened, he tried to strangle his wife. He was rehypnotized as an emergency measure, and allowed to grind his teeth again.

A traveling salesman always became panicky when he had to take a plane or train trip. Hypnosis "cured" him of this. He then enplaned without difficulty, but after his first trip had been completed he started to hallucinate and had to be hospitalized in the "disturbed" ward of a psychiatric hospital. He should not have been hypnotized.

A housewife was hypnotized for childbirth. She was told to practice hypnosis at home (i.e., to do self-hypnosis). She did so, using this to withdraw farther and farther into a dreamworld of her own until she became paranoid and seemed headed for a schizophrenic break. She should not have been taught self-hypnosis.

A schoolteacher with severe back pain was completely cured of this symptom in one hypnotic session. But his pain was what psychiatrists call a depressive equivalent. As long as he could focus on the pain, he could keep from feeling depressed. With the cure of his symptom, this was no longer possible. He jumped out of a seventh story window a few days later.

How does the American Psychiatric Association regard hypnosis?

It regards hypnosis as an aspect of the doctor-patient relationship. As such it has all the potential for treatment and for harm that characterizes the doctor-patient relationship, but to an intensified degree.

Both the American Medical Association and the American Psychiatric Association have issued statements terming hypnosis a psychiatric procedure and recommending that instruction in the subject be through departments of psychiatry in medical schools, teaching hospitals, or psychiatric training centers.

According to the February 15, 1961, "Statement of Policy of the

American Psychiatric Association on Hypnosis," whoever makes use of hypnotic techniques must, therefore, "have sufficient knowledge of psychiatry, and particularly of psychodynamics, to avoid its use in clinical situations where it is contraindicated or dangerous. Although similar dangers attend the improper or inept use of all aspects of the doctor-patient relationship, the nature of hypnosis renders its inappropriate use particularly hazardous. *For hypnosis to be used safely, even for the relief of pain or for sedation, more than a superficial knowledge of the dynamics of human motivation is therefore considered essential.*"

The American Medical Association in various statements, reports, and brochures about hypnosis has emphatically and repeatedly stressed this.

What kind of training in hypnosis is adequate for medical purposes?

Training in hypnosis, to be adequate for medical purposes, should be within a medical school or teaching hospital, under its committee on curriculum, within its department of psychiatry but in conjunction with those other departments of the medical school or teaching hospital in which the physician-in-training is primarily interested, and should stress not hypnosis but physician-patient relationships. In such a course patients should be selected and assigned so as to provide the physician-in-training with a well-rounded experience in relation to his own type of practice, so that his basic learning experience will derive from clinical assignments.

According to the eighteen-page A.M.A. Council Report on "Training in Medical Hypnosis" (May 1962), the most important requirement for the hypnotist is "that he acquire an understanding of the basic principles of psychiatry, and certain basic psychiatric skills."

General practitioners, dermatologists, and other nonsurgeons ligate and suture as a matter of course, but suturing is nevertheless a surgical technique. There can be no nonsurgical use of the suture. Likewise, there are no nonpsychiatric clinical uses of hypnosis even though physicians in general practice, in obstetrics, in physical medicine, and in the various other nonpsychiatric medical specialties may and do hypnotize patients for medical purposes.

Where can such training be obtained?

For physicians already in practice, such training is at present obtainable in only one medical school in the country, the graduate school

of the University of Pennsylvania, which first gave a course of this type on a half-day-a-week basis from December 1960, to June 1961.

Both the American Medical Association and the American Psychiatric Association feel that training in all aspects of hypnosis should be made available to all physicians requesting it. There is, however, as of April 1962, an almost complete lack of personnel able to do this teaching, and of training centers where under proper auspices such training can be secured. A considered effort is now being made to overcome this. Fourteen medical schools, for instance, have expressed interest in exploring ways of training professional personnel to cope with the teaching and other obvious problems involved. Six medical schools now have under consideration courses comparable to the one offered at the University of Pennsylvania.

Do hospitals admit lay hypnotists to their delivery and operating rooms so that patients can be hypnotized by them for operation or delivery?

No. A number of organizations, none of them recognized by the American Medical Association or the American Psychiatric Association, have been training so-called *hypnotechnicians* for this purpose. Hospitals in various parts of the country have received requests to admit such hypnotechnicians to their staffs.

This is neither indicated nor advisable. We normally expect surgeons, when they do even simple appendectomies, to have the necessary background and training to take care of whatever complications may develop once the abdomen has been opened. No lay hypnotists can have the necessary background and training to qualify them for teaching or practicing what, in their announcements, they term "medical hypnosis." By advertising that they teach or practice this, they may actually be violating the medical practice acts in a number of our states.

Is hypnosis used in conjunction with psychotherapy?

It can be. Patients, while hypnotized, can be treated by all the more usual psychotherapeutic techniques. At the Phipps Psychiatric Institute of the Johns Hopkins University School of Medicine, psychiatrists-in-training learn, on an elective basis, to handle patients on hypnotic levels. They are closely supervised and at first proceed exactly as they would if their patients were not hypnotized, granted the same verbal and nonverbal productions; in other words, after hypnotizing the patient, they at first proceed in treatment with that patient in the same way as they would if he were not hypnotized. Later they begin to make

use of a number of highly specialized maneuvers that at first glance, but only at first glance, seem possible only in the hypnotic interpersonal relationship.

Some of these are fantasy-evoking techniques. Some are on motor behavioral levels. Some seem a combination of both. They are limited mainly by the ingenuity of the therapist. They vary with his personality, his background, his training, his clinical competence, and his knowledge of personality dynamics.

It is, however, the ongoing psychotherapeutic process, not the hypnosis, that is of prime importance.

It is for this reason that in 1961 the American Psychiatric Association stated that hypnosis is appropriately and properly used in the course of therapy only when its employment serves therapeutic goals without posing undue risks to the patient. Like all other medical procedures, when utilized it calls for all examinations necessary for proper diagnosis and formulation of the immediate therapeutic needs of the patient

Is there a possibility that the subject will not come out of the trance state?

Yes. This is not frequent, but it happens.

During the past several years, a good deal of time has had to be expended in helping to extricate a number of hypnotists from bad situations that resulted from their psychiatrically naïve use of hypnotic techniques. One patient, according to her hypnotist, was "completely normal," but he nevertheless was unable to terminate the hypnotic trance. Her eyes remained tightly closed. Almost three hours had to be spent with her psychiatrically. For a while it seemed as though emergency psychiatric hospitalization would be needed. The patient, before being hypnotized, had been struggling to prevent the onset of a catatonic schizophrenic psychosis. The hypnosis functioned as an added factor that helped push her into an overt psychotic state. She then utilized her eyelid closure, which the hypnotist had used as part of his trance-induction technique, to blot out the outside world and by means of this symbolically to blot out herself, to destroy herself, as well.

Has hypnosis been used for self-destructive, antisocial, and criminal purposes?

Yes. A number of examples have already been given. Some further thought-provoking cases were summarized in an article by Milton Golin that appeared in the March 1962 issue of *Medicine At Work*:

"Seventy-five psychiatrists reported 114 cases of psychosis triggered by hypnotic measures. . . . Cases were cited where hypnosis induced psychopathological states in the hypnotist himself. . . ."

". . . Not all cases make the police blotter. Early this year a hypnotist-psychologist told Maryland investigators he was hired to 'allay the fears' of shareholders in a building and loan association which is now in receivership. . . ."

What is being done to protect the public?

In 1960, Texas pronounced criminal sentence against an unqualified nonmedical hypnotist, who was "curing" headaches and other complaints by hypnosis, for violation of its Medical Practice Act. In a number of states, Better Business Bureaus have exposed hypnosis quackery. The Food and Drug Administration has seized records that make false claims purporting to teach both hypnosis and self-hypnosis. The A.M.A. is now setting minimal training standards for the use of hypnosis, so that it will be placed in its proper psychiatric perspective.

Hypnosis will take its place as a technical instrument in psychological and medical research, and as a psychiatric technique in the general medical armamentarium.

Its use for entertainment purposes is in the same category as the selling of tickets to the public for admission to watch excision of a brain tumor or the performance of a biopsy.

What differences exist between the literary and the scientific treatment of hypnotic phenomena?

Hypnosis can be used as a potent research tool in psychological and in medical research. The dentist and the physician make use of it on a highly selective basis for pain control, as a tranquilizing agent, and for symptom suppression. In addition, in highly specialized psychiatric practice it is utilized as an adjunctive technique in the treatment of some patients with neurotic or psychotic disease. These uses are described in detail in a number of books, including:

- a) *Hypnosis and Related States*, by Margaret Brenman and Merton M. Gill
- b) *A System of Medical Hypnosis*, by Ainslee Meares
- c) *Hypnotherapy in Clinical Psychiatry*, by Harold Rosen
- d) *Hypnotism: An Objective Study in Suggestibility*, by A. Weitzenhoffer
- e) "Medical Uses of Hypnosis," G.A.P. Symposium #8

In science fiction and science fantasy, hypnosis is sometimes treated realistically and sometimes not. Edgar Allan Poe, for instance, stresses its life-sustaining properties—his tubercular patient (M. Valdemar) lives beyond his normal life-span as long as he is hypnotized, but once this ceases “he becomes a mass of loathsome . . . putridity.” In the world-famous novel by George Du Maurier, Svengali hypnotizes Trilby and makes a celebrated singer out of her. However, Trilby’s voice was a golden one before she was hypnotized. Svengali, her hypnotist, gave her voice-training on hypnotic levels hour after hour, day after day, month after month, and even year after year. This is much more realistic than a great deal of the so-called research now being published on the subject.

HYSTERIA

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What is hysteria?

The hysterical patient defends himself against recognition of an untenable conflict, wish, or impulse by repressing and excluding it from consciousness, and by developing a physical disability or a memory deficit that helps to allay the conflict. The physical dysfunction resembles a condition that the patient believes could ensue from an illness or injury, and therefore the disability is one that could be caused volitionally or by hypnotic suggestion. However, in hysteria the motivation and creation of the symptoms are unconscious. For the person to consciously or willfully maintain the disorder for long periods would be difficult or virtually impossible, but when it is attempted in order to achieve some gain such as avoidance of responsibility or monetary benefit, the person is not hysterical but is malingering. Since the hysterical disorder serves to relieve an internal conflict, the patient is usually free from anxiety and is indifferent to his condition.

What are the different types of hysteria?

There are two types of hysteria: conversion hysteria and anxiety hysteria. The unmodified term "hysteria" refers to conversion hysteria, the condition discussed in this section. Anxiety hysteria is a synonym for phobic reactions, but in psychoanalytic literature it is sometimes used to designate anxiety states. In anxiety hysteria the person defends himself against an unacceptable impulse or wish by developing severe anxiety in certain places or situations, which he then fears and avoids. (See *Phobia*)

What are the physical and psychological symptoms?

The symptoms of hysteria take many forms, generally resembling a disability that could be caused by a disorder of the central nervous system: a loss of muscular control, disturbances of sensory perception, and defects in memory or consciousness. However, examination reveals

that the disability only mimics a condition that could be created by damage to the nervous system.

The hysterical patient may suffer paralysis of virtually any part of the body that is ordinarily under voluntary control, for example, both legs or a hand or finger cannot be moved. The use of the vocal cords may be lost, or impairment of laryngeal muscles may interfere with swallowing. In contrast, a wide variety of muscular movements may occur involuntarily. A classic form of hysteria resembles epileptic convulsions, at times with coital or orgasmic movements. A person may be unable to stand or walk because of inability to maintain balance. Wild flinging movements can occur. However, the hysterical patient rarely sustains injury in falling. Vomiting, coughing, and hiccuping can be hysterical in origin. Muscular spasm may interfere with urination or cause painful intercourse in women.

In the hysterical patient, perception of sensation in some portion of the body may be lost or disturbed but the affected area does not follow the proper anatomical lines for a neurological disorder. This type of sensory disturbance can usually be altered by suggestion. Complete or partial blindness, or varying degrees of deafness can occur. Hyperacuity to sensation may produce itching, pain, or bizarre sensations.

In all forms of hysteria, memory is affected, at least to the extent of forgetting the disturbing circumstances that have precipitated the hysterical condition. Hysterical patients usually are unable to recall periods of their childhood, and other gaps in memory can be found. Somnambulism, trance states, and prolonged sleep can be hysterical manifestations. The more serious memory impairments leading to loss of identity will be discussed in another part of this article.

Typically, the patient who is suffering from a hysterical symptom remains blandly unconcerned, or at least emotionally indifferent, to his disability. But not all patients are typical and many are noticeably depressed. Frequently the hysteric insists that everything is fine and that he would be happy if not for his ailment. The denial of any sources of concern such as are present in the lives of everyone, may lead a physician to consider the diagnosis of hysteria.

What causes hysteria?

A person faced by a situation with which he cannot cope, or fearful of acting out an unacceptable impulse, represses recognition of the dilemma and develops a physical symptom that helps resolve the conflict. Thus, a soldier who fears that he will strike an officer

may develop paralysis of his arm, or a woman who is sexually tempted may become unable to walk. The conflict and the anxiety it produces is converted into the physical symptom. The repression or dissociation of the conflict-producing situation may lead to more extensive memory loss. The development of hysterical symptoms forms an unconscious flight into illness that relieves the person of responsibility and prevents the carrying out of an unacceptable act or the reawakening of a childhood traumatic occurrence and the anxiety that had accompanied it. Persons who develop hysteria are usually predisposed by having developed a psychological pattern of defending themselves from experiencing anxiety by repressing unpleasant memories or awareness of unacceptable sexual and aggressive impulses. There are a variety of theories concerning the precise process by which the emotional conflict is converted into the hysterical symptoms.

Is hysteria related to sexual development?

In a broad sense, all psychogenic illnesses are related to the person's psychosexual development. It is generally held that hysteria, particularly when it occurs under peacetime conditions, is closely linked with the repression of sexual impulses. It is believed that the person had experienced some sexual trauma or seduction in childhood that had created anxiety. The experience could not be assimilated, and memory of the event had been repressed. In adolescence or adult life, new experiences and even awareness of sexual desire that would again arouse the memory of the childhood experience are also repressed with the help of the hysterical symptom. Although Sigmund Freud at first believed that all hysterical patients had actually gone through a seductive *experience* in childhood, he later recognized another factor, namely, that hysterical patients may need to repress their adult sexuality to prevent the recollection of childhood incestuous *fantasies*.

Might hysteria be caused by physical as well as psychological reasons?

No, hysterical disabilities do not have a physical basis. However, an accident or an illness can provide favorable circumstances for the development of hysteria; for example, a soldier who has had difficulty continuing in battle and has had impulses to run away may suffer a hysterical paralysis after being wounded slightly; or, a woman who cannot deny her husband sexual relations may, following an automobile accident, develop a symptom that prevents sexual activity.

How is amnesia related to hysteria?

A "fugue" state, popularly termed amnesia, is a form of hysteria. A person represses or dissociates his entire past life in order to escape from a serious predicament. He forgets his identity, wanders away from his customary surroundings, and suddenly realizes that he does not know who he is or how he arrived where he is. He may assume a new identity and start a new life, but more commonly he is found wandering about, or he seeks help. With rare exceptions, a person in a fugue state can be helped to regain his identity and memory by strong suggestion, hypnosis, and through the injection of sedative drugs. When the person recovers his identity, he is unable to recall what had taken place during the fugue state; but with help the person can remember this period. The reconstruction of the events uncovers a period when the patient had consciously been seeking to forget who he was, sometimes as an alternative to suicide. A head injury can contribute to such breaks with the past, partly because some loss of memory for the events immediately preceding a head injury commonly does occur, and partly because the person may hold the popular but erroneous belief that a blow on the head can cause "amnesia." Although all hysteric individuals have a proclivity for repressing and forgetting disturbing situations, the person who develops a fugue state finds his entire life situation unbearable and seeks a way out.

How is multiple personality related to hysteria?

Authentic cases of fully developed multiple personality are rare. A person whose ability to express instinctual drives is constricted, develops a secondary personality that can fantasy and live out wishes that the primary personality cannot accept. The individual shifts from one personality organization to the other as portrayed in exaggerated form in Robert Louis Stevenson's story, *Dr. Jekyll and Mr. Hyde*. The primary personality is not aware of the behavior of the secondary personality and has no control over it. Individuals with multiple personalities are highly dramatic but are unconscious of the secondary or tertiary roles they live out. In contrast to fugue states, the person does not escape from himself by leaving his environment, but by the shifting of personalities. Some multiple personality formation is more closely related to schizophrenia than to hysteria, but in schizophrenia the functions that are split off are isolated and not organized into a relatively autonomous personality. (See *Schizophrenia*)

Can a person become hysterical through contact with a person showing hysterical symptoms?

There are strong suggestive influences in the development of hysterical symptoms. The patient frequently is identifying himself with a person suffering from a physical disability or from hysteria. When people are living in rather isolated groups, as in the army or in a boarding school, a hysteric symptom can become epidemic. Members of a religious sect may develop the same hysterical condition through identification with a leader or saint. The dancing mania of the Middle Ages provides an example of a pandemic (affecting the majority of people in a country or number of countries) hysteria.

Can any person be subject to hysteria? Are some persons more susceptible than others?

Perhaps everyone develops transitory hysterical symptoms on occasion, particularly if the forgetting of painful incidents is included. However, many persons do not develop any significant hysterical symptom under any circumstances, while some individuals can readily defend themselves against experiencing anxiety by developing a hysterical reaction.

Does susceptibility to hysteria seem to be inherited?

Although some eminent authorities have considered that hysteria occurs in genetically predisposed persons, there is no clear evidence to confirm this assumption. Most contemporary psychiatrists in the United States consider that the predisposition is based upon the person's psychosexual or psychosocial development, that is, the configuration of early life experiences.

Is there a hysterical personality type? If so, what are its characteristics?

A great deal has been written about the hysterical personality, but disagreement concerning the basic configuration continues. Hysterical personalities are commonly held to be egocentric, dramatic individuals with many attention-seeking techniques. They are likely to be dependent, demanding persons who had been deprived of love during their early childhood. Some psychiatrists emphasize the development of a lifelong pattern of avoidance of recognition of anxiety-provoking situations and the habitual repression of hostile or sexual

impulses. The hysteric's emotions are labile but shallow. Women who are unconsciously sexually provocative and utilize flirtatiousness to gain attention, although frigid and fearful of sex, constitute a hysterical personality type. The situations arising in response to their unconscious provocation can precipitate hysterical symptom formation. Excitable behavior that is commonly termed hysterical may be a prominent personality trait because such individuals react to stressful situations by immature childlike tantrums rather than by facing the problem and seeking to cope with it. Several recent studies indicate that hysteria does not occur only in personalities that fit the conventional descriptions of the hysterical personality.

Are women more susceptible to hysteria than men? If so, why?

Under peacetime conditions, about 75 per cent of the cases of hysteria occur in women. For centuries hysteria was never diagnosed in men. The word *hysteria* derives from the Greek word for uterus, and the symptoms of hysteria were thought to be caused by the uterus wandering into the affected part of the body. The reasons for the predominance of hysteria in women have not been definitively clarified. The woman's role in life tends to make her more passive and dependent and more likely to use passive-dependent ways of escaping from difficulties. Many cultures require greater repression of sexuality in women than in men. The woman's psychosexual development often permits less complete repression of childhood incestuous fantasies, which then may interfere with adult sexuality. Girls may be more subject to sexual seduction than boys. Such factors may combine to make women more susceptible to hysteria.

Are persons more susceptible at different ages? If so, why?

Early adolescence, when youth must contain the upsurge of sexual impulses that follow puberty, is probably the most vulnerable period. However, early adult life involving courtship, marriage, and childbearing is also a time of high susceptibility.

How is hysteria related to Freud's theories of psychoanalysis?

Psychoanalysis originated from Freud's efforts to treat hysterical patients. Prior to Freud's work little was known concerning the nature and cause of hysteria. The French neurologist, Jean Martin Charcot, under whom Freud studied, produced and relieved hysterical symptoms by hypnotic suggestion. Freud, dissatisfied with the transitory

benefits obtained by hypnotic suggestion, followed the lead of his mentor and colleague, Josef Breuer, and had his hypnotized patients relive forgotten past traumatic experiences and rid themselves of the repressed and pent-up emotions associated with them. He then found that hypnosis was unnecessary, and that the results were superior if the subject regained the experience simply by saying whatever came into his mind—the technique of “free association.” Many basic psychoanalytic concepts such as the understanding of repression, the dynamic unconscious, transference phenomena, and the discovery of the oedipal conflict were achieved through Freud’s study of hysterical patients.

Does the incidence and form of hysteria vary with the type of society?

In general, hysteria is more common in uneducated societies reliant upon superstition, magic, faith healing, and miracles. Training to scientific modes of thinking decreases the incidence. Customs that rigidly condemn sexuality provide a more fertile soil. Revivalistic religious groups in which religion and sexuality fuse or are confused may foster hysteria or even mass hysteria. During World War II troops from backward and poorly educated areas developed hysteria in combat more frequently than others. Less sophisticated societies are likely to produce the more dramatic types of hysteria, such as hysterical seizures, total paralyses, etc.

Is hysteria experienced by persons of primitive cultures? If so, why?

Hysteria certainly occurs in most primitive societies. Belief in black magic, witchcraft, and the force of various taboos provides a suitable setting. Although theory may lead to the belief that absence of restrictions concerning childhood sexuality would diminish the occurrence of hysteria, very few primitive peoples enjoy such relatively carefree psychosexual development.

Is there less hysteria now than in previous generations? If so, is this an indication that people are emotionally healthier today, or does it mean that disorders are taking different forms?

Although a distinct impression exists that hysteria has become less common in recent years, several studies indicate that the incidence has not changed appreciably during this century. The question cannot be answered with assurance. The diagnosis of hysteria is not applied as broadly or as loosely as formerly. Some patients whom Freud called

hysteric would now be given other diagnoses. It is apparent that the more conspicuous forms of hysteria are seen less frequently in urban centers. Other types of neuroses, notably obsessive-compulsive disorders, have become more common or are diagnosed more frequently than in the past. (See *Character Structure*)

What can be done to prevent or reduce the occurrence of hysteria?

Improved child rearing practices, with provision for the affectional needs of the child and with reasonable permissiveness concerning self-recognition of sexual and hostile impulses, may help. Raising the educational level and medical sophistication of the population has been effective. Prompt diagnosis and treatment reduce the usefulness of hysteria as a defense and as a means of attaining secondary gains (external gains, for example, personal attention and financial gain derived from an illness). As with all psychiatric disorders, improving the stability of home life and providing early treatment for personality disorders are among the more promising prophylactic measures.

Can hysteria be a symptom of another disorder?

Yes. Hysterical symptoms frequently are a defense against depressions which become manifest if the hysterical defense is inadequate. Some hysterical patients eventually become schizophrenic, the hysterical symptoms forming an attempt to ward off the personality disorganization. Commonly hysterical symptoms are intermingled with other neurotic disorders.

Can hysteria be a cause of another disorder?

Yes, in the sense that prolonged disuse of a limb can lead to contractures of muscles and immobilization of joints, or that hysterical vomiting results in malnutrition and vitamin deficiencies.

What are the treatments for hysteria? What has been the success of these treatments? What factors influence their effectiveness?

The preferred forms of therapy seek to uncover the underlying conflict and permit catharsis (healthful release of ideas through "talking out," accompanied by appropriate emotional reaction) of the repressed emotions in order to release the patient from the influence of childhood trauma and modify the personality structure. Treatment that simply removes the symptoms does not prevent a relapse or the

substitution of a new symptom. Psychoanalysis is probably most suitable, but less intensive and shorter psychotherapeutic techniques usually suffice. Psychoanalysis is not suited for some patients, and economic factors may also prevent its utilization.

Symptomatic cure can often be brought about by hypnosis or strong suggestion; and some patients, particularly those suffering from a single hysterical symptom, may not have a recurrence. Most psychiatrists are reluctant to treat the symptom alone, not simply because a new symptom may be substituted, but because a more serious personality disorder may replace the hysteria. However, it is sometimes advisable to remove the symptom by suggestive techniques before it becomes firmly established, and then carry out treatment of the personality disorder. The elimination of the symptom often requires doing away with any secondary gain the patient achieves through illness, such as insurance payments or oversolicitude of parents, and requires finding a means of rewarding recovery rather than illness. Symptomatic treatment is usually efficacious only when the patient's life situation has altered so that he no longer needs the symptom—as when a soldier develops a hysterical paralysis in combat and learns that he will not be returned to combat after he recovers.

The severity of the symptoms does not provide a clear indication of the severity of the personality disturbance. Some patients who have multiple symptoms may do well, and others who have a single minor paralysis may be very resistant to treatment. The success of treatment depends upon the personality assets of the patient. A person who has made a reasonably mature adjustment to life and has developed his symptoms under severe stress has a more favorable prognosis than a childlike, self-centered, and overly dependent person. Patients who have been unable to cope with the everyday problems of life and tend to regress readily to immature, dependent behavior have an unfavorable outlook, at least without very intensive treatment.

IDENTITY

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What is identity?

The literal derivation of "identity" is "absolute sameness" (Latin *idem*—same); but the alternative meanings of "personality" and "individuality" are nearer the meaning intended here. Other related terms include: ego, self, identification, individuation, person, persona, character, temperament, identity strength, ego strength, etc. Identity is a complex formed by the qualities that an individual presents to others, interacting with the qualities that other people and the social and material environment present to the individual. The term embraces a wide range of phenomena. (See *Personality; Ego; Culture and Personality*)

Does identity formation follow a definite course?

Two main divergent schools of thought exist: the dynamic view that the mutual identification of child and parent with each other enables the child to recognize his own self; and the behavioristic view that identity builds up by a continuous process of conditioning. Here the dynamic view will be elaborated.

The child becomes identified with his parent through "empathy"—broadly speaking, the ability to experience the feelings of others; for example, the toddler experiences his mother's disgust at his soiled pants, a process that can extend to inanimate matter, i.e., distress felt over the mishandling of precision machinery. The toddler's explorations develop his empathy, which enables him to recognize intuitively what he can and cannot do with his body or with his human relationships—what brings satisfactions, what hurts, and so on. Thus he comes to appreciate the boundaries, strengths, and weaknesses of his own body and its place in the space-time continuum. Later, more abstract aspects of identity formation complement the primitive body image. (See *Parenthood and Child Rearing; The Family in Illness and Health*)

What is the nature of identity and its variations?

Identity is an organized continuum in space and time, resistant to vicissitudes, but in a state of continuous change and adaptation. It has continuity, coherence, and flexibility; its tendency toward integration gives strength.

Identity may have many facets; thus one individual, at various, often overlapping times, may appear as a persuasive schoolteacher, a stern mentor, a lover, an indulgent father, a bridge-club member, a dutiful son, the life and soul of the party, a bear romping with his four-year-old son, a religious penitent, and so on. All these aspects of identity contribute to the whole.

Other individuals vary little from the behavior of their most important identity role, e.g., the pompous and domineering man who never relaxes.

The multiple facets of identity formation tend to have a hierarchy of importance to the individual. To some people, nationality is their most important identity; to others, social position, marital status, or profession. Some people reject aspects of their identity, and seek escape or change.

How are individuals identified by other people?

They are identified mainly by the hierarchy of their identity formation, which may be a complex or a relatively simple system. When the latter, the individual's identity may stand out in sharp relief; but a complex system may be mistaken for weakness or lack of personality.

Is identity a consistent property?

In the case of the healthy personality, identity normally presents a consistency that might be described as its style or basic plot. This is not static, because it must necessarily include the continuity of the change of identity that occurs as the individual passes from one phase of living to another, e.g., from childhood to adolescence to adulthood; from junior employee to head of department; and so on. (See *Character Structure*)

Is the identity subject to disorders?

Yes. These may result from weakness or inconsistency of identity formation, or from breakdown under stress. Identity disorders are characterized by confusion, partial loss, and pathological change, rather

than by complete loss. The popular notion of a dual personality is an oversimplification, although hysterical dissociation may give the appearance of a radical change in personality, whether temporary or long lasting. (See *Stress*)

What causes disorders of identity?

Commonly they are caused by emotional tensions too great for the individual to tolerate and, less commonly, by certain organic and psychogenic mental disorders. Thus, tension caused by emotional frustration may result in the individual dissociating from or abandoning one aspect of his identity and concentrating, as it were, on some other aspect. For example, the strongly maternal woman with a drive toward nurturing and succoring might, under frustration, become dominating, controlling, and hard.

When an identity disorder is caused by a serious mental illness, disintegration and deterioration are more likely to result. These cases often present a confused picture in which aspects of previous identity formation can be recognized in a general state of deterioration. (See *Anxiety; Emotional Crises*)

Does change in identity indicate disorder?

Not necessarily so, but a major change of identity nearly always raises considerable stress. When change in identity is forced upon the individual, as in the case of the refugee of high professional position in his original country who has had to adapt to an inferior social role in another country, the healthiness of such change will depend upon the identity's qualities of continuity and coherence as well as its flexibility.

Conscious change of identity, including change of name and otherwise, is commonly motivated by a desire to escape from an existing identity felt to be burdensome, or alternatively, to move toward a new fulfillment from which the old identity bars the individual. Change of religion, of nationality, and of political philosophy are often thus motivated. In these cases the issue of whether the change is mentally healthy or otherwise may be decided by the objectivity of the individual's relationship formation. It appears that change of name (except when covered by social convention, e.g., at time of marriage) is likely to be experienced, to some extent, as a psychically mutilating experience.

What are the manifestations of a loss or confusion of identity?

In addition to obvious changes in personality and in habitual behavior, there will often be a serious loss of memory. This may appear dramatically but transiently as a hysterical fit, collapse, and loss of consciousness. When more prolonged, identity loss may take the form of a hysterical fugue (amnesia and physical flight from the immediate environment). Rarely, a severe loss of functional capacity occurs, which, for example, may take the form of regression to a babyhood level of demand to be fed and cared for. More commonly, although memory of name and social situation may be lost, the subject's behavior does not otherwise draw attention to his condition. Individuals have managed to live and function for long periods without their memory loss being suspected, provided that they did not meet with acquaintances from their former life who expected them to react according to an identity they had lost.

In other, less dramatic, changes of identity, memory may be retained, but a deep-seated change of emotional attitude takes place so that matters with which the person was previously identified may be repudiated. This process usually leads to radical changes in loyalties and arouses strong defense mechanisms, as illustrated by the well-known fanaticism of the convert.

A third type of identity loss is in the direction of depersonalization. The subject, as it were, retreats from his own humanity and becomes more automatic, unresponsive to emotional ties, and disinterested in relationships. (See *Hysteria; Memory; Mental Mechanisms*)

Can the loss of identity be desired unconsciously?

Loss of identity, when not caused by external forces, is usually the result of unconscious pressures to secure release from a situation that is intolerable, consciously or unconsciously. Thus, loss of identity can be both motivated and maintained by strong unconscious drives. (See *Motivation*)

Is there a direct connection between loss or confusion of identity and mental illness? What changes in identity take place in mental illness? Are these changes reversible?

Some forms of mental illness, notably schizophrenia and organic dementia, cause loss or confusion of identity that presents an appearance of chaos and deterioration to the observer. However, more commonly, loss or confusion of identity is the result of emotional stress

leading to a flight from reality; it represents the seeking of a neurotic solution to difficulties, and has little relationship with psychoses.

All changes that take place in identity are potentially reversible, but where the changes are due to mental illness, recovery is dependent on the course of the mental illness itself. Even those changes due to progressive schizophrenia, though hardly reversible, are themselves subject to change. Where organic disease is the cause, recovery from the disease usually restores the identity position, e.g., recovery nearly always takes place in cases of delirium due to acute toxic illnesses. (See *Schizophrenia*)

How can one gain knowledge of one's identity?

People vary greatly in their insight into the significance of their identity. In general, only the more thoughtful and inturning people gain benefit from making an appraisal of their position, the type of life they lead, and their dependence or otherwise on social activities and on human relationships, contacts, and so on. (See *Insight*)

Does knowledge of identity help to solve personal problems and can it be painful or harmful?

People differ very widely in whether they are helped by self-knowledge toward the solution of personal problems. Those people who depend upon an intellectual working out of their problems will probably find such knowledge valuable, but others who depend more on intuition may find that intellectual knowledge merely undermines their confidence in feeling their way through life.

To gain insight into aspects of one's own identity formation may be painful, like any other aspect of self-revelation, but whether such knowledge will prove harmful or not depends upon the integration of the individual and his defenses against anxiety. In the case of the poorly integrated person, growing awareness of unpalatable truth about identity may precipitate hysterical flight. Where integration is sounder, new knowledge may be employed for the solution of problems.

Does psychological treatment help to improve knowledge of identity?

Only incidentally and insofar as an identity problem may be an important factor in emotional maladjustment. In principle, psychotherapy should be undertaken in respect to the whole problem rather than any single aspect. (See *Psychoanalysis; Psychotherapy*)

Much is written nowadays about "strains of modern life." Is there anything that can be done in the field of identity formation to help people to withstand such strains?

People who are living under conditions of continual movement and change, as in the case of a modern industrial community, need a style of identity formation that is both coherent and flexible. In communities living an unchanging life from generation to generation, a fixed identity position gives the greatest degree of security. If children reared in a simple and formal style of living are subjected, as young adults, to rapidly changing and different conditions, identity breakdown is not uncommon.

Therefore, children brought up in an industrial community need to experience satisfaction in change and making adaptations from their earliest years. If a community is moving from one style of life into another, innovations should not be presented to the children at a rate greater than their capacity to adapt. The new life needs to be presented to children in ways that bring them greater satisfactions than the life to which they were accustomed. (See *Social Factors in Mental Illness; Mobility and Mental Health; Social Change and Mental Health*)

What about retirement and old age and the question of identity breakdown?

This is an important current social problem, because of increased expectation of life and a tendency toward earlier retirement. In many countries there is a marked discrepancy between the expectation of life of men and women at the age of sixty-five. Many men find their most important identity in their career, which, being relinquished, establishes a strong tendency toward early breakdown and death. On the other hand, when home and family are the summit of the hierarchy of a woman's identity, old age represents the logical evolution of the basic plot of identity from that of wife to mother, to grandmother, and possibly to great-grandmother. (See *The Aging and the Aged*)

What are the significant areas of current research into identity?

- 1) The promotion of positive identity formation, e.g., a boy should be brought up positively to be a boy rather than something that is not a girl. This is very important in the avoidance of prejudice formation.
- 2) The prevention of strain on identity formation, e.g., study of

the conditions necessary to enable a child to accept his evolving identity.

- 3) The relationship between identity formation and identification with the parent figure; and the importance to the individual of group membership.
- 4) Leadership; the effect of change of name; "family romance" (the invention of a fantasy parentage) and its relation to adoption; and the pathological material obtainable from the therapeutic reintegration of psychotic patients into group life.

(See *Child Development*; *Psychosexual Development in Man*; *Adoption*; *Family Psychotherapy*)

IMPOTENCE

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What is impotence?

Impotence is the inability of a man adequately to perform sexual intercourse. In common usage, the term applies only to men.

What are the physical causes of impotence?

These include certain relatively uncommon defects in the genitals present at birth plus those that may result from disease or injury at any age. Impotence may, for example, follow an operation for prostate disease, it may accompany an organic disease of the brain or spinal cord, or it may be the result of endocrine deficiency.

What is psychic impotence? What are its causes?

This is impotence due to emotional conflict or other psychological disturbance. There are many causes of psychic impotence including some that go along with mild to severe mental illnesses. Everyday causes, however, include inexperience, shyness, embarrassment, or shame about sexual matters. Neurotic conflicts including unconscious fear of women or hostility toward them can also cause psychic impotence.

What are the various types of impotence?

Physical impotence can be divided into two types: congenital and acquired. Psychic impotence can be classified according to the basic emotional disturbance or according to the form it takes. For example, it may mean inability to have an erection, failure to hold an erection long enough to have intercourse, or, even with an adequate erection, inability to have an ejaculation.

Is impotence a constant problem?

Most men are impotent occasionally, but some men who have serious emotional problems about sex (or about the opposite sex) are consistently impotent.

What is the rate of impotence among American men?

This varies markedly, and there are no reliable statistics. The Kinsey studies found very few cases of absolute impotence in men under thirty-five years of age—less than 1 per cent. The rate of incidence of occasional impotence is unknown.

What might cause sporadic impotence in a man who usually enjoys normal sexual relations?

Any one condition or a combination of circumstances may cause occasional impotence or be factors in habitual impotence. These include alcoholic beverages, lack of privacy, physical or mental distractions, strange environment, new partner, grief, fear of causing pregnancy, and other fears.

Is the sex drive weaker in impotent men than in other men?

Probably not, and certainly not necessarily.

Does the size of the penis have an influence on a man's potency?

No, unless the man has unrealistic or neurotic attitudes about the size of his penis.

Does impotence ever lead to disturbing effects?

Yes, but it is difficult to know which is the cart and which the horse. A depressed man may become impotent, and then become more depressed because of his impotence. He may suffer anxiety about his adequacy, about satisfying his wife, and about how he will do the next time. He is likely to attribute impotence to childhood or adolescent masturbation (which is erroneous, unless guilt over masturbation is a factor) and become apprehensive about that. Impotence is a symptom of something else, but it is a disturbing symptom that can produce others.

Does masturbation provide a satisfactory outlet for the impotent?

Yes, in the sense of providing a discharge for sexual tension. No, in that it is usually considered second best and likely to be associated with painful feelings of inadequacy, shame, and guilt. Masturbation can be a neurotic solution for men whose impotence is caused by fears or guilt related to sexual intercourse or the prospect of parenthood.

Can impotence or premature ejaculation be created by excessive masturbation or excessive intercourse?

Yes. There is a limit to everything. Although a man may be capable of one or a dozen ejaculations in the course of a few hours, he still develops fatigue and loss of sexual desire in time, and must have rest. There is great individual variation, however, in the capacity to have frequent ejaculations, age being one important factor.

Can external conditions such as weather, altitude, etc., cause impotence?

Yes, both as they affect sexual desire and cause fatigue. Few men, for example, are interested in sexual intercourse in extremely hot, humid, muggy weather and, if they attempt it, may be impotent. Extreme altitudes affect fatigability and can certainly produce impotence until one is acclimatized.

Does impotence have any relationship to sterility? Is it possible for an impotent man to impregnate his wife?

Impotence decreases the chances for successful vaginal penetration and may therefore cause sterility, but an impotent man may nevertheless impregnate his wife. It is a matter of "percentages." If a man has an ejaculation at all, however, his sperm may find their way to an available ovum and fertilize it.

Could impotence be a symptom of homosexuality?

We generally consider homosexuality itself as a symptom. Homosexuality and impotence can be—and usually are—symptoms of some underlying (unconscious) psychosexual disturbance or attitude. When homosexuality is the result of an identification with the opposite sex or of unconscious fears, guilts, or hostilities with respect to women, then impotence may well be one manifestation of the total problem.

Could impotence be a symptom of mental or physical disorder?

Yes, impotence is always a symptom of something else. In about 95 per cent of cases, the underlying problem is mental, i.e., an emotional or psychological disturbance or conflict. The other 5 per cent of cases have a physical basis. As a rule of thumb, when impotence is the principal problem or complaint, the causes are psychological.

Organically determined impotence is usually associated with other more distressing and disabling symptoms. Every case, however, requires both physical and psychological evaluation.

Can anxieties created by impotence cause mental or physical disorder?

Yes, in the sense that a person can "worry himself sick" over any problem causing intense feelings of guilt, shame, inferiority, etc. Impotence itself does not have these effects, but a person's reactions to it can. Reactions to impotence vary from resignation to severe depression, from insomnia to loss of weight and frequent illnesses.

Are there any physical characteristics that might indicate a man's impotence?

No. The only exceptions might be gross genital abnormalities observable in a men's locker room or upon physical examination. Even here, appearances might be misleading.

Are there any emotional characteristics that might indicate a man's impotence?

One might surmise impotence in an overt homosexual, but one might be badly mistaken on both counts—the impression of homosexuality and the impression of impotence. The same can be said of impressions based upon physical appearance, interaction with women, choice of vocation, and so on. Men—particularly older men—who molest children or practice other perversions are often impotent, and it is commonly held that their impotence causes their perverse behavior. This may be partly true, but it is more often the case that both the impotence and the deviate sexual behavior are symptoms of more fundamental problems, including the regressive changes that may occur with aging. It should be added that it is not uncommonly the child who seduces the adult, impotent or not.

What is a eunuch?

A eunuch is a castrated male or, more strictly, a male castrated before puberty. The term could be applied to any male who has lost both testes (sex glands) by disease or removal or who has never developed them. The term does not have wide currency in American medicine.

What are the different types of eunuch and how are they distinguished?

The two principal types are those who became eunuchs before puberty and those whose testes were destroyed or removed after puberty. In the former group, puberty brings little change of voice, only meager development of secondary sex characteristics (pubic hair, etc.), and the persistence of small boy or "feminine" body-build. In the latter group, diminished sexual desire may be the principal change.

Are eunuchs always sterile?

Yes, because they have no sex glands to produce sperm (sex cells).

What treatment has been successful for different types of eunuchs?

This writer has never heard of any successful treatment for testes that have been removed or otherwise entirely destroyed. Replacement therapy with male hormones may favorably influence secondary sex characteristics.

Can a castrated man be potent?

Yes. His sexual desire may be reduced, but he can still have erections. There is no physical reason for him to be impotent.

Is impotence more prevalent in a specific age-group?

Yes. According to the Kinsey studies of more than four thousand males (with ability to have an erection as the criterion), 0.1 per cent are impotent at twenty years of age, 0.8 per cent at thirty, 1.9 per cent at forty, 6.7 per cent at fifty, 18.4 per cent at sixty, 27 per cent at seventy, and 75 per cent at eighty. This type of impotence therefore varies directly with age.

Is there a greater incidence of impotence in highly civilized and urban cultures than in the more primitive?

It is generally assumed that the answer is "Yes." Most of the psychological factors that promote impotency are characteristic of urban, highly civilized cultures or, at any rate, are more prevalent and intense there. Inasmuch as 95 per cent of impotence is on an emotional rather than a physical basis, and since the neurotic conflicts, "nervous tensions," and related stresses and strains that contribute to impotence are particularly conspicuous in the middle and upper classes of civilized urbanites, we assume that these males are most vulnerable. Most cases

of impotence discovered by the Kinsey studies were among "upper-level, educated males."

Is there a high degree of impotence among the mentally ill?

Yes. This is obviously so when one defines mental illness in the broadest sense of the term. Many emotional conflicts that enter into neurotic and other mental illnesses derive from or are associated with sexual conflicts, one symptom of which may be impotence. Most cases of impotence, in men under thirty-five, are psychologically caused and may, therefore, be associated with neurotic or more serious mental illness.

Is there a high degree of impotence among criminals?

There are no reliable statistics, but it is supposed that there is a high incidence of impotence among men convicted of sexual offenses. The impotent man may have to "prove himself" in some way that may lead to criminal behavior. In most cases, however, the impotence and the criminal behavior are probably symptomatic of an underlying sexual or other maladjustment.

Is there a greater degree of impotence in men than of frigidity in women?

All available statistical studies indicate that frigidity is more common than impotence, but there is considerable variation in these reports. The Kinsey studies on absolute frigidity (i.e., never an orgasm) indicated that 25 per cent of women were frigid during the first year of marriage, 17 per cent at the fifth year, 14 per cent at the tenth year, 12 per cent at the fifteenth year, and 11 per cent at the twentieth year. It must be remembered, however, that lack of orgasm does not necessarily mean lack of satisfaction and that so-called frigidity can be less upsetting to a woman than impotence to a man. It is also noteworthy that impotence increases with age, while frigidity—up to a point at least—diminishes with age.

Does every man go through a period of impotence at some time during his life?

The chances are that he does. If not a period of impotence, he will have occasional occurrences of impotence. Occasional impotence is no cause for concern at any age and must be expected with advancing years.

Can a sexually experienced man become impotent?

Yes, of course. Experience is no insurance against age, fatigue, or satiation, for example. The wise man will not attempt intercourse under adverse circumstances, but experience and wisdom are not always joined in holy wedlock.

Is it possible for a man to be impotent with one sex partner and potent with another?

Yes, and this may be because of the man's conscious or unconscious attitudes toward his partner, or because of the partner's response or lack of it during sexual intercourse, or both. Some men, for example, are impotent with women they idealize and potent with women they deprecate as "prostitutes."

Does the length of time between sexual relations affect a man's potency?

This depends upon many factors including age, freedom from physical fatigue or emotional stress, and the emotional climate between the two sexual partners.

In what ways could an impotent man express his frustrated or repressed sexual desires?

Such reactions are as varied as the natures of men. They range from supine acquiescence to a malevolent fate to violent, vindictive outbursts of frustrated passion. While the "average" impotent man may be somewhat depressed in his private world, he is likely to develop excessively masculine or virile compensatory outlets of one sort or another, and these may range from collecting "dirty" postcards to "compulsive" mountain climbing. Really repressed (i.e., unconscious) sexual desires may express themselves in dreams or in neurotic symptoms in addition to impotence.

How does impotence and the fear of impotence affect the man in his relationships with people outside his home?

There is no set pattern, any more than for anything else, about which a person may feel inferior, ashamed, fearful, or guilty. The behavior will vary with the intensity of such feelings. It varies also if the "blame" is centered in the man himself, or is projected onto his wife or fate.

To what extent does a man's early sex education and experience influence his potency?

Education and experience instruct and they also influence expectations. When they prevent or alleviate shyness, clumsiness, fear, and guilt, they will reduce the incidence of impotence. On the other hand, when they overemphasize the ideal of simultaneous orgasm and the ideal of always gratifying the marital partner, they may impose burdens rather than lighten them. Sex education is frequently a mixed blessing and, in any case, may still be unable to influence neurotic problems.

Could an extended courtship involving sexual activities (not culminating in intercourse) affect the male's potency after marriage?

Probably not. People who engage in "heavy petting" without intercourse usually find other outlets, deliberately or spontaneously, and besides they have greater capacity for enduring frustration than "moderns" sometimes give them credit for. From another point of view, couples who accept an *extended* sexually frustrating courtship may well be predisposed to sexual difficulties in marriage anyway. Young couples who do not intend to have intercourse prior to marriage generally find ways of courting without excessive sexual frustration.

What feelings of guilt or hostility may arise in an impotent man?

Guilt is often related to a man's feeling that he is not gratifying his wife, and anger to the feeling that the wife is responsible for his impotence, which may or may not be the case. Feelings of inadequacy breed anger, while guilt may also spring from the fantasy that boyhood masturbation caused the impotence.

Is it possible for an impotent man to fall in love?

Yes, definitely. An impotent man may, indeed, love his wife too much, but in an idealized way that, for him, precludes such "animal" desires as sex. Falling in love may also be a reaction formation against unconscious hatred, or it may express the wish to be taken care of as a child rather than the more adult desire to be a husband and a father. "Falling in love" is a deceptive business.

Why are some potent men constantly fearful of becoming impotent?

The chances are that such a fear is the symptom of unconscious problems about sex, whether fear or guilt because of earlier masturbation or about sexual matters altogether, or because of fear, shame, or

anger directed for some reason toward the sexual partner. The same emotional problems that make for impotency can cause fear of impotence. With some men the fear is a punishment of conscience (superego) for the very enjoyment of potency.

Do some men actually desire to be impotent?

Yes, at least unconsciously; and the reasons, again, have to do with their own attitudes toward sexuality or toward their sexual partners. Such attitudes are usually not conscious and represent neurotic conflicts.

What effect does the changing role of women in modern society have on impotence in men?

There is considerable evidence to suggest that woman's changing role intensifies emotional conflicts within herself and may aggravate the "war between the sexes." There is widespread confusion, especially among the educated strata, as to what is "masculine" and what is "feminine." These confusions and the emotional attitudes engendered by them are often reflected in that most delicate barometer of interpersonal relations, sexual intercourse. Impotence, of course, is only one indicator of stormy weather in this area.

Can impotence in a husband be the cause of physical and/or mental illness in his wife?

As a rule of thumb, one can assume that the wife of a consistently impotent man has sexual problems of her own prior to and apart from his impotence. We have to ask: "What was this woman's need to marry an impotent man?" Again, if the husband is consistently impotent: "Why do the partners continue to frustrate themselves by repeated attempts at sexual intercourse?" Moreover, the wife may be partly responsible for the impotence. There are no simple answers, but the point is that any physical or mental illness in the wife of an impotent man is probably not primarily the result of his impotence.

To what extent does a wife's attitude toward sexual intercourse affect her husband's potency?

This depends upon how secure a man feels in his own sexuality and to what extent he is concerned about his wife's responses. If the wife must be free and responsive for the husband to be free of fear and guilt and to feel secure in his masculinity, then he may well be im-

potent if she is in conflict and unresponsive. A man who has no doubts about his potency and is little concerned about his partner's response is not likely to be unduly affected by his wife's attitude about sexual intercourse. An overly active, aggressive, or deprecating wife may render her partner impotent.

To what extent is a wife's general attitude in the home and toward her husband a factor?

Sexual intercourse mirrors the total relationship between husband and wife. It is a psychosexual relationship, particularly among more sensitive men and women. Latent or overt dissatisfactions or conflicts easily affect the sexual relationship. In this way, a woman's dissatisfaction with her role, or her hostility (for any reason) toward her husband may—if he himself is somewhat vulnerable—affect his potency. But one may have to ask: "What was his need to marry such a woman?" The problem is seldom hers alone.

Do contraceptive measures affect a man's potency?

Most couples resent contraceptives even though they use them, and this resentment can affect their sexual response. If a diaphragm, for example, is inserted after sex play begins, the interruption may cause impotence. The use of condoms may cause premature ejaculation or may so reduce stimulation of the penis as to produce impotence. Conflict between partners about the use of contraceptives (or the type to be used) may have the same effect. Even the use of pills can be disturbing when one or both partners have mixed feelings about preventing pregnancy.

Does impotence in a husband indicate loss of love for his wife?

It may, but there are many other possibilities. Apart from the rather unusual reasons for impotence and advancing age, a number of stresses or emotional conflicts in the husband—having little or nothing to do with his love for his wife—may be responsible. If impotence occurs in the course of a happy marriage, the wife will be wise to consider external factors before concluding that she is no longer loved.

Do some husbands use impotence as a weapon against their wives?

Yes, they do. In the first place, impotence is sometimes unconsciously designed to frustrate and injure the wife, or it is a defense against the unconscious fantasy of using the penis as a destructive

weapon. The fact of impotence itself, however, may be used consciously as a weapon by placing all of the blame onto the wife or as an excuse for demanding other types of sexual gratification that may be offensive to the wife. These situations are complicated, however, and the wife is more often than not a party (albeit unconsciously) to the arrangement.

What is the nature of the hostility or anxiety feelings that may arise in a wife as a result of her husband's impotence?

Where these feelings arise, they are likely to be because the wife is sexually frustrated, and therefore angry, but at the same time suspects that she herself may be inadequate or at fault, and therefore anxious.

Are there any physical habits or characteristics in a woman that might lead to impotence in her husband?

Yes, but much depends upon the man. A sexually insecure or conflicted person is easily made impotent. Some men become impotent if their partner is ashamed, frightened, or repelled; others, if she is too eager or aggressive. Feelings can express themselves in postures or movements, in unresponsiveness or apathy. Any of these can destroy the potency of some men.

Can frigidity in a woman cause impotence in her husband?

Yes, but this usually involves a husband who already has psycho-sexual problems.

How do the problems brought about by impotence affect other aspects of the home and family life?

Inasmuch as impotence is itself a symptom, it is likely that the home atmosphere is already affected by whatever factors cause the impotence. The fact of impotence, however, tends to compound and intensify other problems. Feelings of inferiority, shame, and guilt further disturb the total marriage relationship, and mutual recriminations add fuel to the fire. All of these, coupled with signs of frustration—irritability, moodiness, daydreams of infidelity or divorce—inevitably affect and may seriously disturb the totality of family life.

Does a family's attitude toward sex and sex education affect the probability of impotence in its children?

In general, stupid, inhibited, or neurotic attitudes in the parents tend to breed such attitudes in their children. It is helpful if parents

can be natural about sexual matters and give appropriate answers to children's questions as they occur. Unfortunately, however, conscious good intentions cannot always overcome unconscious neurotic attitudes, and the latter influence children more tellingly than the former. Parents who are markedly more inhibited or markedly more "emancipated" than others in the community in which they live are most likely to nurture sexual conflicts in their children, and these may result in impotence or frigidity.

Can there be a happy marriage between an incurably impotent man and a sexually normal woman?

Yes, because the conditions of happiness are many and varied, and they do not necessarily include a conventional sex life.

Is it advisable for an impotent man to get married in the hope that marriage will solve his problems?

Even though it might work out occasionally, the chances are that such a course will be no solution for the man. It involves using the woman concerned, and this will involve deception or planned experimentation. Love might be able to conquer all, but the usual result will be an overburdened marriage and the promise of mutual frustration.

How can a wife aid her husband in conquering the problem of impotence?

For many couples the first and most important step would be recognition and discussion of it as a problem to be solved. Some reading material might be reassuring and otherwise helpful, particularly as regards some of the facts about sexual intercourse—atomy, positions, techniques, and so on. An agreement to seek professional help might be a next step. Psychoanalysis for one or both partners might be the treatment of choice if severe inhibitions or neurotic conflicts are significant factors.

What steps might an impotent man take to help himself before contacting a psychiatrist or other physician?

Apart from what has just been suggested, a man can remind himself that impotence is not the result of earlier masturbation or other childhood sins. He might tactfully suggest to his wife that she modify preliminary sexual or other activities that disturb or annoy him. In addition, he should attempt intercourse only at times of optimum re-

laxation and freedom from worry and fatigue. A calm and sympathetic mutual analysis of all of the elements involved in sexual intercourse may reveal those that spell the difference between gratification or its absence.

What are the treatments for physically caused impotence?

Some of the physical causes are treatable, but others are not. Adequate medical diagnosis is essential. When the foreskin of the penis is too tight, circumcision may help. Endocrine (hormone) therapy is effective for some. Other measures to produce optimum health sometimes tip the balance.

Could the drinking of alcoholic beverages stimulate an individual's potency?

Yes, if done in moderation. A glass of wine or two is sometimes helpful, but drunkenness is likely to make matters worse. It is a matter of promoting a sense of relaxation and well-being. Alcohol may inflame the passions and melt away the conscience, but it is dangerous medicine at best. It is much better to discover and treat the underlying cause or causes.

What are aphrodisiacs? Are they successful in the treatment of impotence?

An aphrodisiac is anything that stimulates or intensifies sexual desire. The term is usually applied to drugs (including alcohol) that have this effect. Agents that arouse or heighten sexual desire may overcome impotence, but they may fail inasmuch as very passionate men can nevertheless be impotent. Desire does not guarantee performance. If, however, the effect is also relaxing, reassuring, and comforting, contributing to a sense of well-being and self-confidence, then the symptom of impotence may be cured even though the underlying cause may not be.

Are drugs and tranquilizers useful in treating impotence?

Drugs that produce a sense of well-being and vigor are sometimes used, but it is difficult to evaluate their effectiveness. They may be useful for the timid or inexperienced, but they are probably of little use as a permanent crutch. In any event, their unregulated use can be dangerous. Tranquilizers serve to diminish agitation, but often they

depress sexual interest. Certainly they are not a proven remedy for impotence. Granted that some impotent persons might respond to stimulating drugs and others to sedative or tranquilizing drugs, these agents should be carefully regulated as to frequency and dosage. At best they are treating a symptom rather than underlying causes.

Has there been any success with hormones in the treatment of impotence?

There are relatively few cases of impotence in which hormones are effective. In these few cases, however, they can be very helpful. Careful evaluation by a physician is required before offering hope through this kind of therapy. Hormone therapy is bad if it postpones dealing with the real issues.

How is local anesthesia used in treating impotence?

Anesthetic ointments are sometimes applied to the head of the penis to reduce excessive sensitivity in cases of premature ejaculation, which is a kind of impotence. There can be little pleasure from an anesthetized penis. It is much better to deal with more basic causative factors.

What has been the success of psychiatry, including psychoanalysis, in the treatment of impotence?

Psychiatric treatment, including psychoanalysis, is frequently effective in the treatment of impotence. It may take the form of sex education, reassurance, ventilation of fear and guilt about sexual matters, or the analysis of unconscious neurotic conflicts about sex or about the opposite sex. The wife may require treatment also, if through inexperience, timidity, or conflicts of her own she is contributing to the problem. Inasmuch as perhaps 95 per cent of cases of impotence are psychologically caused, some form of psychotherapy is usually the treatment of choice.

Has hypnosis been successful in treating the impotent?

Hypnosis can help some impotent men. A skilled hypnotist will, however, not be content simply to remove the symptom (impotence), but will also deal with its underlying causes. For maximum safety, hypnosis should be employed only after psychiatric evaluation and as part of a total psychotherapeutic program.

Can a change of environment bring about a cure of impotence?

Yes, at least temporarily, and sometimes permanently. Often the change of environment means a rest, a vacation. Getting away from the demands of family and business and the stresses and strains of urban life will spell the difference for some impotent men. This, however, is a symptomatic cure, and the symptom may recur in the more usual environment. For some, however, the chance to relax, gain experience, and develop self-confidence may establish a new sexual pattern and bring a permanent cure.

What is the prognosis of cure among impotent men?

There are no reliable statistics about prognosis because of the many factors that enter into impotence and the several forms it may take. In general, the outlook is poor for impotent men who are old and feeble, who have chronic debilitating illnesses, who have severe, chronic mental illnesses, or who are excessively shy and inhibited. Otherwise healthy men whose impotence springs mainly from inexperience, inadequate sexual information, and "run of the mill" neurotic conflicts can usually be helped. In between is a group that may be cured only over a longer period of time with, for example, psychoanalysis or other intensive psychotherapy.

What can social, religious, and educational agencies do to prevent attitudes and fears that may lead to impotence?

There are already numerous community programs dedicated to sound, wholesome sex education. This, of course, begins with young parents and extends through premarital counseling by ministers, planned parenthood clinics, and so on. These services are not universally available, of course, nor are the programs equally helpful. Certainly all health and welfare agencies in the family life and educational fields should reexamine their programs with an eye to unmet needs and, where indicated, improve and extend them.

Based on current research and studies, what might be predicted about the prevalence and treatment of impotence in the future?

Inasmuch as only about 5 per cent of impotence is due to physical factors, the bulk of the problem is in the area of mental health. There is no present indication of vast or spectacular change in the incidence or treatment of impotence. There should, however, be gradual im-

provement as preventive programs increase and improve, and as treatment facilities are more available and more freely used. Widespread acceptance of impotence as a medical—usually psychiatric—problem is a second step. The first is the kind of family life education—courses on marriage and the home, for example—that will help prevent it. The old saying, “As the twig is bent, so the tree is inclined,” applies to all aspects of personality development including particularly the capacity for mature sexuality and family life.

INSIGHT

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What is insight?

Insight has been defined in different ways by different authorities, depending on their fields of interest. In ordinary usage it refers to the capacity or act of understanding a situation, other people, or oneself, and the ability to apprehend meaning and relationships of data that are presented. In psychiatry the term "insight" is used to express a number of concepts ranging from recognition by the patient that his symptoms are abnormal phenomena, to a judgment by the physician that the intellectual, affective, and volitional components of the personality are functioning harmoniously instead of at cross-purposes.

Actually, insight is an elusive concept. Some of the ideas regarding it are superficial and often naïve. In some instances, so-called insight is nothing but hindsight; in others, it is simply verbal and descriptive, quite remote from insight in depth. An important kind of personality insight is historical; it implies an understanding of the sequence of events and reveals the resourcefulness and difficulties involved in the search for past experiences. Insight is concerned in some way with the relationships of various levels of self-awareness and has something to do with unconscious as well as conscious processes.

Is there a difference between insight into ourselves and insight into others?

There is a difference, although insight into oneself may facilitate an understanding of others. Because the human personality is of such infinite variety, the possibilities of error in judging other people are also infinite. In any event, the dynamics of self-insight and insight into others are different. For one thing, the resistance against understanding certain things about oneself that would be painful or unpleasant is not involved when one is dealing with another person, unless that other person's attitudes or reactions are too much like one's own for comfort or unless it is a question of an important "object" in one's life. It should

be understood that insight is always relative, whether it has to do with others or with oneself. Self-insight, particularly, is difficult to attain. To have major blind spots about oneself is a universal human failing. A knowledge of psychology will not correct this. Many psychologically sophisticated people have little insight into themselves, however much they perceive correctly about the other fellow.

What are the functions of insight?

The answer depends on the kind of insight one has in mind. Superficial insight may make the individual feel better, enable him to suppress his symptoms and to correct some aspect of his behavior that gets him into trouble with other people, but the same may happen in the absence of any insight at all. There can be recovery from mental disorder without insight, and there can be no recovery despite insight. However, in dealing with seriously disturbed personalities in the psychoneurotic range, it is felt that the provision of dynamic insight is one of the major goals of therapy. It is not enough for the patient to know that his symptoms are abnormal phenomena; he must arrive at an understanding of their origin and development, with sufficient emotional reinforcement of that understanding to make it really meaningful. This is dynamic insight that may lead to a change in the personality itself, with a strengthening of the ego in its struggle to bring harmony between reality and the instincts.

How can true insight be distinguished from apparent insight?

True insight is a controversial subject. According to some authorities, insight is at best usually a mixture of self-knowledge and rationalization. Many psychiatrists accept as useful the so-called dynamic insight—the insight that brings about shifts of energy within the psychic apparatus. Yet even dynamic insight may be false. It is not possible, as a rule, to verify the “truths” that emerge during therapy. The proper connections of a symptom to previous traumatic events are often difficult to establish.

Certainly what helps the patient may be something quite apart from his facing, at long last, some “truth” about himself that he has refused to see before. This is not strange because fantasy can be as troublesome as fact for the patient; indeed, infinitely more troublesome. For in the psyche of man, fantasy is as valid as truth. At unconscious levels the wish and the deed are the same. It should not be surprising, therefore,

that the interpretation a patient accepts during therapy—perhaps one which opens the door to insight—is sometimes false in terms of reality.

In what ways do people vary in their capacity for insight?

They vary from pole to pole, depending on biological equipment, personality constellation, life experience, and ways of handling anxiety. Many apparently “normal” people show little insight into themselves or others, either because consciously or unconsciously they shun awareness of it or because temperamentally or for other reasons they are incapable of achieving it. On the other hand, some psychotic patients, even in the schizophrenic group, are not without insight. More frequently, of course, a lack of insight is one of the most impressive things about psychotic patients. It is of interest that the patient with cerebral arteriosclerosis often shows insight for a long time—understands the nature of his symptoms and maintains the basic features of his personality.

There is no evidence that men differ from women in the capacity for insight, which, in its highest form, includes understanding of the effect of one's behavior upon others, a sense of ethics, and the acceptance of responsibility for oneself. While not a determining factor, age plays a certain role in the dynamics of insight. As a rule children lack insight of the type we are talking about. The child must pass through long stages of development and a multiplicity of experiences before he can make the mature and sensitive judgments that insight requires.

As the individual ages, there may or may not be a decline in whatever insight has been achieved. Under the burden of physical and mental infirmities and social and economic losses, some people decompensate rapidly and one of the first capacities to go may be insight. The fact that others withstand similar stress remarkably well supports the claim that insight is a state of personality or ego functioning. The quality of insight possessed in the past has much to do with the quality that will be displayed in declining years. When there has been little in evidence before, there will be less in the present and future, and the difficulties of the individual and of those who must cope with him will be magnified accordingly.

Is insight a sign of high intelligence?

Insight is not a direct property of high intelligence, though some of the processes that operate in insight are related to those upon which critical judgment associated with high intelligence is based. Many

highly intelligent people have no insight into themselves or others. Because of unfortunate experiences of early life or experiences that to them were traumatic, they have never achieved the personality integration required for constructive insights. The same could be said of some geniuses, but, on the whole, one of the most impressive features of the great geniuses of history has been the powerful insight they have manifested in many different directions. Many average people have all the insight they need to function happily and successfully in life. There are even some in the lower intelligence ranges who do well enough. It is true, however, that the mentally retarded labor under greater handicaps than other people and have less chance to achieve the degree of personality integration that permits sensitive self-awareness and skill in human relations.

Undoubtedly creativity and insight are related. The writer, the poet, and the artist, for example, all draw heavily on personal resources including self-understanding together with understanding of others to produce the work that others recognize to be a realistic portrayal of some or many aspects of the human situation.

What is known about the sources of insight?

The sources of insight are internal and external. Internally they include elementary and highly complex mental processes, plus feelings that become attached to the contents and products of mental life. From the environment come experiences that favor or hamper insight. Cultural, educational, religious, and other forces mold the individual's way of life. The most important external forces are the people one encounters, particularly those important to one's emotional security.

Insight is acquired, not inherited, except in the sense that as a dimension of personality and intellect it depends to some extent upon the biological equipment with which one is born. Insight itself does not emerge in early childhood. However there are experiences in early life that make a real difference in how the personality will develop and, therefore, help determine whether insight will be forthcoming.

Inasmuch as insight is acquired, it follows that it may be cultivated to some extent, unless the personality is pathologically distorted. Education provides a basis for a better understanding of man, as well as for the exercise of intellectual faculties that participate in insight. To that extent it can perhaps be said that education helps produce insight. Nevertheless, education does not necessarily bring self-understanding.

A certain degree of self-insight must be present if the individual is to

grasp the significant aspects of a human situation. He who would understand another must be able to share the feeling of the one he is observing so that he may be able to attach to events the significance appropriate to that person's part in the events.

What causes a lack of insight?

Basically, a lack of insight is connected with the defenses used by the personality to cope with anxiety. These defenses operate unconsciously. Insight is prevented by the process of repression, which keeps out and ejects from consciousness the ideas or impulses that are unacceptable to it and are fraught with anxiety. The repression prevents emergence into conscious life of perspectives that would give rise to painful insights. (See *Mental Mechanisms; The Unconscious*)

What are the manifestations of a lack of insight?

There are many—some obvious to almost everyone, others elusive and requiring the observation of the trained observer before they can be identified.

In everyday life, the phenomenon of what Harry Stack Sullivan called "selective inattention" is often unmistakable. Selective inattention is the ability to exclude from attention something that is actually very significant. It enables the individual to overlook important aspects of events that happen almost every day. It is the classic means by which we do *not* profit from experience.

"Selective inattention," states Sullivan in his *Clinical Studies in Psychiatry*, "is very impressive when one observes that it could not possibly act so suavely and so eternally at the right times, unless there was a constant vigilance lest one notice what for some obscure reason one is not going to notice." Thus people are able to overlook the most glaring implications of certain acts of their own. By being inattentive in this way they become increasingly expert in doing the things they are determined not to notice, though everybody else sees quite clearly what is going on.

Repression would be an extreme example of selective inattention, and it is to this force that the psychiatrist must often address himself in the treatment of psychiatric patients.

In what ways can lack of insight be limiting to the individual?

A lack of insight is always limiting to some degree. It is often a serious handicap to self-fulfillment, militating against the development

of real potentialities and against effective interpersonal and human relations. It tends to lead to evasion of responsibility and the avoidance of difficult decisions. It may well lead to psychiatric illness.

The psychopathic personality is an excellent example of the superficially normal person who is totally lacking in insight. Capable of expressing in words the noblest of attitudes and the deepest of feelings, he turns immediately around and perpetrates offenses that belie his verbal commitments. He is not embarrassed by this, however. Even to people who have caught him in all manner of deceptions, he will swear on his word of honor that it will not happen again, and he is incredulous that his vow is not taken seriously. He never sees himself as others see him and appears to be incapable of the emotional experience necessary for achieving insight into himself and others. (See *Psychopath or Sociopath*)

Can a lack of insight be protective?

Lack of insight is undoubtedly protective, so far as the individual is concerned. It is because he has been unable to face certain unpleasant truths about himself that he has resorted to defense mechanisms that keep them out of awareness. He may develop unfortunate, perhaps highly disabling, psychiatric symptoms as a result, but these are preferable, he finds, to the insight that would bring a flood of anxiety.

John R. Reid and Jacob E. Finesinger, in *The Role of Insight in Psychotherapy*, have pointed out, in the case of some elderly people with more liabilities than assets, that insight would only aggravate the injury. They have further pointed out that "unless insight gives the power to change, if not the past then at least emotional attitudes toward it and the future that grows out of it, with less guilt and more courage, then insight may only be another sad variation on the theme of failure."

How can insight be brought about through emotional experience?

Emotional experience is essential to the achieving of beneficial insight. Sometimes the experience is provided by a real trauma that makes the patient aware of his unrealistic behavior, blithely ignored before, or it may be brought about by losses or afflictions of one kind or another (grief or pain, for example) that place matters in an entirely different perspective. Joy or other strong emotions may similarly bring insight to one who has had serious blind spots about himself and others. In such cases a spontaneous shift in dynamic forces seems to occur.

Corrective emotional experience is of great importance in psychiatric patients. Two major kinds of emotional insight are emphasized in literature. The first involves an experience in which the patient, in grasping some knowledge about his behavior, has had a simultaneous release of rather intense emotion—a cathartic experience, as it were, following which his symptoms have been relieved. Among psychiatric casualties in time of war, this cathartic or abreactive experience has been an important method of therapy. A second and more complicated kind of emotional insight involves making a connection between a concept and a feeling. The patient succeeds in merging an important idea with a relevant emotion, which he has been unable to do before because the two have been dissociated in some way. The concept and the feeling belong together and with the insight-gaining experience they are henceforth experienced together. Thus, an important hurdle is negotiated in the struggle toward mental health.

How does one gain insight during psychotherapy?

Psychotherapy is an experience between two people in which one is seeking help in bringing about a change in himself for the purpose of feeling better, working better, or overcoming some distressing symptom. He may be able to reach the desired goal with little if any insight into himself and the origin of his disorder. He may even recover without insight. There are patients who simply present to the therapist a long list of complaints and symptoms and, having done so, immediately feel better and get rid of their symptoms. Nevertheless, insight plus benefit is the most desirable psychotherapeutic achievement.

In the course of study of a given patient, the psychiatrist will gain much insight into the factors responsible for the patient's reaction. If a certain amount of that insight can be passed along to the patient, he will know at least something of his areas of weakness and perhaps be able to cope with them more successfully. Unfortunately, insight passed along in this way does not often work, and deeper, more prolonged courses of psychotherapy are called for.

The type of insight achieved with psychotherapy depends upon the method used by the individual specialist. Most of the modern methods aim at emotional insight. The aim of psychoanalysis and other forms of deep analysis is dynamic insight. Psychoanalysis bares the springs of habitual behavior, bringing the patient gradually and not without suffering to an appreciation of the relations between buried experiences and current unconscious conflicts out of which have come both the

neurotic components of his personality and the neurotic symptoms themselves. To appreciate this relationship allows the release of emotions and, simultaneously, a shift of energy relationships within the personality. As a result, various forms of energy are released and become available for constructive purposes. According to Gregory Zilboorg, in *The Emotional Problem and the Therapeutic Role of Insight*, insight cannot be partial, intellectual, or emotional. It is rather a state of personality or ego functioning—"the ultimate and crowning point of integration."

How does one gain insight through introspection?

Introspection may supply valuable intellectual insights, but it is doubtful that it helps many people to reach the insight that would help them overcome defense patterns and modes of reaction embedded in the personality since early childhood. Only the exceptionally gifted person, knowledgeable in the complexities of human psychology and experienced in its clinical study, could be expected to do so. Sigmund Freud was one who succeeded, and the fact that he did so continues to be a source of amazement to those who have traveled the long, hard road to self-understanding with the help of a trained psychoanalyst. Introspection can, on the contrary, lead to a kind of false insight, to a dangerous concentration on fantasy and the unreal, to the serious detriment of the personality.

Can the gaining of insight ever be harmful to the individual?

There are cases in which the gaining of insight into the origin of symptoms has led to more serious illness. The strength of the personality has to be such that it can withstand the anxiety aroused by discovering what lurks deep within. Otherwise a psychotic reaction may occur, dangerous not only to the patient but to others. If the reaction happens to be of the schizophrenic type, the patient may arrive at psychotic insight. He then succeeds in putting together those things that have terrified or confused him before. By devising a pathological way of seeing reality, he is able to explain his abnormal experiences. If he finds that people are "plotting against him," and particularly if he is able to narrow down the circle of "conspiracy" to one or a few individuals, he may take the steps he finds necessary to protect himself. He has insight, but the insight is founded on mental processes that occur only in a state of psychosis.

Is there a connection between lack of insight and mental illness?

Yes, if we define lack of insight as impaired functioning of the ego. However, if what we mean is that the individual has no appreciation whatever that there is anything wrong with his thinking and behavior, then the connection is not valid. A great many psychotic patients in the initial stages of illness suspect the truth. Later they tend to lose this insight. A recent study shows that newly hospitalized schizophrenic patients were generally aware that they were in the hospital for psychiatric reasons. Interestingly enough, after a brief course of chlorpromazine, and considerable clinical improvement, they began advancing other reasons for being there, although they could still see that the other patients were in need of psychiatric treatment. By contrast, a group of patients who had been hospitalized for a number of years were entirely lacking in insight. The insight, however, is not necessarily lost forever. It is not uncommon for such patients, when treated with the new methods that psychiatry possesses today, to recover and to show a certain amount of insight.

What are the significant areas of current research into insight?

Much of the significant work in the area of insight continues to be done by psychoanalysts. With the extension of psychotherapeutic programs for groups and individuals, more attention is being paid to the problem by other psychotherapists also. Studies in the area of memory are also of importance. For example, Wilder Penfield's work on electrical stimulation of the temporal lobe has isolated three categories of memory: recording, recalling, and reliving. In his work, the recorded fragments have been recovered as recollective hallucinations, or as more or less organized recollections ranging from verbal symbols only to sensory imagery, and further to actual reliving of the past with a full complement of somatic components.

The solution of the many problems that remain, in the field of insight, awaits further clarification of the influence of conscious thought on unconscious factors, as well as the reverse, and on the process of becoming ill and becoming well. At present it is difficult to explain why insight does not always exert a therapeutic influence, and why the mode of its attainment varies so widely from individual to individual.

INSTINCT

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What is instinct?

The term "instinct" has a long and complicated history, marked by a great deal of controversy in philosophy, psychology, and psychiatry. In a most general sense, instinct refers to some inborn, unlearned aspect of behavior or thought. Instinct is sometimes used to denote a mild, inborn predisposition or tendency to behave or think in a certain way. At other times, it is defined as a rigid, involuntary, automatic thought or behavior pattern of greater complexity and longer duration than a simple motor act or reflex. Many definitions also include the notion that instinctive behavior is rigidly fixed and cannot be modified or controlled in any way. Like many concepts in the study of mental health, instinct has been used in different ways by different authors.

In this article instinct is defined as a complex, inborn behavior pattern of coordinated motor responses elicited by certain environmental stimuli under the proper internal (physiological) conditions. To qualify as inborn, such a behavior pattern must be capable of being elicited more or less completely the very first time the organism is placed in the proper situation without having had an opportunity to practice, learn, or observe the behavior previously. This does not necessarily mean that no part of the behavior pattern can have been learned. For example, most female dogs clean, pick up, and carry their newborn pups in a characteristic manner the very first time they whelp their young. This is true even when the mothers have been reared, from a very young age, by humans away from other dogs. Thus, these complex patterns of maternal behavior are unlearned. However, it is also true that these instinctive behavior patterns become smoother and more efficient as the mothers become more experienced in caring for young pups. Learning enters the instinctive behavior at the outset and remains a part of the total behavior at all times.

Do instincts actually exist?

Although innate factors such as drives and instinctual demands have often been assigned an important role in theories of personality

and in mental health, there are those who deny the importance or existence of instincts in human beings. This point of view has been expressed by many experimental psychologists, the "behaviorists," in particular. They have become convinced through studying the impressive learning abilities of animals and men, that quite complex and apparently automatic, presumably instinctive, behavior patterns can be learned. This current trend toward denying the existence of inborn behavior patterns in human beings is also traceable to a reaction against the once popular practice of explaining much of human behavior by assuming the existence of one or another "instinct" as an underlying cause. Thus one might "explain" why human beings belong to all kinds of social groups, ranging from nations down to lodges or fraternities, by positing that man possesses a "herding" or "gregarious" instinct. This type of explanation is, of course, quite circular, merely substituting a new term for the phenomenon one seeks to explain. Subsuming membership in all kinds of social groups under the term "gregarious instinct" may signalize essential similarities in various kinds of social behavior, but it does not explain such behavior any more than positing that an "automotive force" explains the working of an automobile—even if the automotive force is attributed to other kinds of vehicles as well. It may be true that joining a social group is an inborn behavior pattern in man, but merely positing this without proof is not acceptable in science. For this reason, many behavioral scientists have grown suspicious of the concept of instinct, refusing to accept it as a principle of human behavior.

On the other hand, very few people question the presence or the importance of inborn factors in the behavior of lower organisms. Much of the behavior of insects, for example, is obviously, and of necessity, innate or instinctive. Many insects emerge from a pupa in the winged form, immediately fly off (without having to learn or practice flying), locate a mate, and deposit their eggs in exactly the right environment to provide the proper food for the larvae when they hatch (which often occurs long after the adults have died, thus preventing learning by imitation of, or association with, adults). Usually, these behavior patterns take place in a very brief period of time with no opportunity to learn the complicated reactions necessary for accomplishing the reproductive functions. Although innate, unlearned reaction patterns that are complex and of long duration are important characteristics of insects and lower organisms, it has been demonstrated that such animals are also capable of learned or noninstinctive behavior. This should

indicate that instinct and learning are not mutually exclusive; that the presence of one in the behavior of an organism does not necessarily exclude the other. Although learning is so evident in human behavior, it does not follow, as implied in the behaviorist position, that instincts are unimportant.

Innate behavior components have been demonstrated by observation and by laboratory experiment in higher animals, including mammals, in which learning is thought to play the predominant role in behavior. Thus, lone female rats will properly prepare a nest and care for their young even though they have been reared in isolation with no previous opportunity to learn the skills of nest-building and mothering. These mother rats exhibit unlearned or instinctive patterns of behavior that enable them to perform adaptively in a new situation. Similar experiments cannot be done with human beings because it would be wrong to subject human infants and children to the rigidly controlled social isolation necessary to prevent an opportunity to observe or to learn behavior patterns. Although there is no direct evidence that instinctive behavior patterns exist, neither is there direct, experimental evidence that such patterns are not present in human beings.

How can we know when behavior is instinctive?

The only way we can be certain that a particular aspect of behavior is instinctive is to rear an organism in a controlled environment where there is no chance for it to learn or observe the behavior in question. A given reaction must then be considered instinctive if it occurs in a normal manner the first time the animal is placed in a situation where the behavior can occur. For example, the male Siamese fighting fish, *Betta splendens*, if reared from birth to adulthood in a separate tank, isolated from all other fish, will exhibit the typical attack behavior, characteristic of this species, immediately and properly the first time it views another male fighting fish. Since such an isolated fish has had no opportunity to learn this response, or to learn to recognize another male, the attack response of this species must be instinctive.

Because it is not possible to use this isolated rearing method with human beings, it is very difficult to decide whether or not a given pattern of human behavior is instinctive. To circumvent this difficulty, it has been suggested that a behavior pattern can be considered instinctive if it occurs universally in the same manner in all the members of a given species. But the universality and uniformity of such behavior does not necessarily prove that the behavior is instinctive. Such species-

characteristic behavior may be due, instead, to a sequence of experiences that are the same for all individuals in that particular species so that the behavior is universally "learned" rather than instinctive or inborn. An illustration of such a universally learned behavior pattern, or *coenotrope* as it is sometimes called, is the species-characteristic song of certain songbirds. While it is true that some songbirds sing the song of their species even if they have been reared in isolation, other species of songbirds will not sing their species' song unless they have heard the song when they were young, or in some cases unless they can hear the song when they reach maturity and first begin to sing. Thus, as adults, these birds, if they have been reared normally, all sing the same species-characteristic song, not because it is instinctive, but because they have all "learned" the same song from their parents.

In human beings the upright posture may be such a universally learned coenotrope rather than an inborn behavior pattern or instinct. A few cases have been reported of human children who grew up in the wilds, apparently having been reared by wolves. These children, when eventually captured by humans, did not have an upright posture. They stood and they locomoted on their hands and knees. This may be taken as evidence that humans universally learn to stand erect, or it may mean that the instinctive, upright posture can be modified by experience or learning.

Are there any instincts in human beings?

Many students of behavior assume that at birth the human mind is a *tabula rasa*, or blank slate, upon which experience is free to write the course of future behavioral development of the individual. In other words, they believe that all human behavior is developed out of simple reflexes that are integrated in a manner determined by specific life experiences. In the course of these experiences the individual learns which reaction patterns are suitable in various life situations.

As mentioned above, this view is popular, at least in part, in reaction to earlier, circular explanations of behavior that overemphasized instincts, and because man has impressive capacities for learning. But the proposition that human beings are peculiarly lacking in instinctive components of behavior is also plausible because it suggests, by implication, that proper rearing and education can produce better adjusted, improved human types. Conversely, the existence of inborn behavior patterns seems to fix limits on the effectiveness of education and child rearing, and it provokes a certain amount of pessimism about the pos-

sibility of changing people and thereby improving society. It is the writer's opinion that, in spite of the philosophical and societal implications, the assumption that human behavior is overwhelmingly a product of experience and learning is not tenable. Convincing evidence for or against the presence of instincts in human beings has not yet been presented.

Aside from its attractiveness from a societal point of view, the proposition that, in effect, all human behavior is learned has little to recommend it. Questionable logical considerations, rather than scientific evidence, underlie its acceptance by behavioristic psychologists. They reason that instincts cannot be seen as such, but must be inferred from less complex, more directly observable bits of behavior. Therefore, they are unwilling to assume the existence of instincts, preferring to work instead with the simpler, more directly observable "facts." Moreover, these psychologists have been impressed with the ease and extent that behavior can be modified by training. From that observable fact they have tended to generalize to a conclusion that all behavior is learned.

Many anthropologists have also promoted the notion that instincts are absent or unimportant in humans. In their studies of varied human societies they note the rich variety of behavior. They might as truly note fixed similarities in human behavior such as walking upright, the manner of carrying out biological functions, or the universal presence, in all human societies, of emotions such as fear, rage, jealousy, lust, embarrassment, etc.

While there is no direct, experimental evidence for the existence of inborn behavior patterns in man, neither is there evidence for their absence. Logical considerations, such as the solid experimental evidence for the existence of instincts in mammals generally and the universal presence of certain fixed behavior patterns (e.g., those listed in the preceding paragraph and in the following question) in spite of varying childhood experiences in different societies, suggest that instincts are present and may play an important role in human behavior.

What are some of the common instincts?

Almost no experimental work has been done on this problem in man. However, a wide variety of indirect evidence from animal research and from introspection of human thought processes and emotions has led Konrad Lorenz and Niko Tinbergen, European students of behavior, to speculate that in man some of the instinctive

behavior patterns are locomotion, food-seeking, sexual behavior, sleeping, care of the body surface, certain aspects of fighting, the inhibition of attack when the victim shows submissive behavior, and maternal or paternal reactions. Lorenz posits that each human emotion which qualitatively can be discriminated by introspection is part of an instinctive reaction to some environmental stimulus. As an illustration, he suggests that all human beings—indeed, all mammals—experience a pleasurable sensation in the presence of any infant mammal. This instinctive response to the babyish aspects of a young animal influences the behavior of adults toward an infant. It may account for the frequent reports of foster-mothering where infants are cared for by adults of another species. For example, female cats and dogs sometimes “mother” baby mice and rats, though they normally, and even concurrently, kill adult rodents. Lorenz believes that the babyishness (recognizable, according to Lorenz, by the relatively large head and eyes, small nose, plump softness, etc.) of the infant rodents elicits instinctive maternal behavior patterns in the adult animals. He cites, as evidence for the presence of a similar instinct in man, the typical human reluctance to harm the young of any of the higher animals and the human tendency to protect and care for young animals.

The concept of instinct in human beings is also important in Sigmund Freud's theory, and it is a key concept in the study of mental health today. However, Freud did not give much attention to instincts as such. He explained psychoneurosis as a pathological resolution of conflict between the instinctual demands of the id, which he defined as the center and repository of instinctual drives, and the control function of the ego, the executive, problem-solving agent of the mind and the personality. Freud also assigned to instinct an important role in the development and maintenance of society. Through the ego's suppression of the id instincts, energy derived from these instinctual forces is sublimated into socially desirable channels so that the individual can contribute toward the growth of civilization and culture. Thus, the instinct to possess some love object that is forbidden by societal taboos, or otherwise unattainable, may give rise to energy which the ego can direct into useful work or creative effort. It is the ego's function to direct the release of instinctual energy into socially acceptable activity rather than to allow the instinctual behavior that society, by and large, deems punishable.

Despite the prime importance of instinct in his theories, Freud did not elaborate on the instincts. He named only two basic instincts—

Eros or *life* instinct and *Thanatos* or *death* instinct. Within these he further differentiated only the sexual instinct, a part of the life instinct. Freud was more concerned with the outcome of conflict between id and ego than with instinct or specific instinctual behavior patterns.

How can instinctual demands affect mental health?

In general, the psychoanalytic movement, evolving from Freud's theories, has emphasized the role of the ego in coping with the environment and the demands of the instincts. Currently, it is fashionable to think more in terms of the ego's ability to handle these demands than to consider the role of the instinctual demands as such. This shift to "ego psychology" first appeared in Anna Freud's classic monograph, *The Ego and the Mechanisms of Defense*, in 1936. Ego psychology has been amplified subsequently by such noted psychoanalysts as Heinz Hartmann, Ernst Kris, and Erik Erikson. Nevertheless, present-day concern with the ego is not in any way a denial of the importance of instinct in mental health. Rather, it is a tacit admission of the basic and supreme power of instinct, a recognition that id instinctual processes must be accepted as given, but that they are relatively inaccessible for study and treatment. The ego then must be trained and nurtured to deal with these potent instinctual demands. Mental health can be viewed as a function of the effectiveness of the ego in coping with the instincts and the environment, both of which are formidable opponents in conflict. This conflict between instinctual desires and the restrictions of society is a basic consideration, but the ego is the agent through which such conflict must be mediated. If the ego cannot control or sublimate instinctual demands, the resultant frustration or societal disapproval gives rise to unhealthy mental states. This is a current view of the ways in which instinctual demands affect mental health. This view is obviously metaphorical, based on clinical experience, and used as a general guide for those concerned with maintenance of mental health. A discussion of some of the specific ways in which instinctual demands are thought, by various writers, to affect mental health is not feasible because there is little agreement on this subject.

Are instincts incapable of being changed?

One prevalent misconception about inborn behavior patterns is that they are rigid and unmodifiable. This belief, implying as it does

a certain uncontrollability of instinctive behavior, is responsible for much of the reluctance to accept instincts in human beings. That instinctive behavior can be modified is suggested by psychoanalytic theory, which is largely an examination of the control, modification, or channeling of instinctual demands into acceptable healthy activity. According to Freud, instinctual energy motivates all behavior, learned or unlearned. It is capable, under the ego's control, of energizing behavior in rich variety. In his monograph, *Civilization and Its Discontents*, Freud suggested that artists and scientists are individuals with strong instinctual desires which the ego has successfully channeled into sublimated artistic and scientific creativity. Thus all art and science, indeed all human progress in its varied forms, can be argued to be due to instinctual drives that have been modified by ego control.

However, it must be noted that from the Freudian point of view it is not possible to modify an instinct. Only the form of the behavior in which the instinctual energy is released is variable according to the Freudian theories. The question of whether or not instincts can be modified has been dealt with more directly by certain experimental psychologists working with animals. Most experimental psychologists accept the behaviorist position that instinctive behavior patterns are nonexistent or unimportant in higher animals. At best, they admit to a very few inborn factors in behavior—the so-called “primary drives” associated with physiological needs such as thirst, hunger, warmth, sex, etc. For the behaviorists, these basic drives function somewhat like Freud's id. They are the motivators of all behavior, and satisfaction of these drives (drinking, eating, etc.) determines what particular behavior patterns will become characteristic of a given individual. Thus, an organism is driven by hunger to seek food. Any behavior that leads to food is stamped in, or reinforced, so that it is likely to reoccur on the next occasion of hunger. Within this framework, which denies the existence of complex, instinctive behavior patterns as they were defined at the beginning of this article, there are no ways in which an inborn factor could be modified, except temporarily when satiated. The primary drives are immutable and function to motivate and to reinforce learned behavior patterns. All behavior is learned and inborn factors are limited only to the primary drives.

But within the ranks of the experimental psychologists, there are those who do not agree with the behaviorists' views on instinct. The leaders in this group are the associates of Lorenz and Tinbergen who call their branch of study *ethology*. This approach to the study of

behavior is based on a careful observation of animals in natural surroundings and on a comparison of the behavior of animals representing a wide range of species. Only after gaining an intimate knowledge of the animal and his total behavior range do the ethologists attempt laboratory experiments to test the hypotheses derived from their observations.

This method of proceeding has led the ethologists to the conclusion that the basic drives championed by the behaviorists can account for only a part of the total behavior of an organism. Observations and experimental investigations of the unlearned behavior of insects and of higher animals reared in conditions that do not permit learning have demonstrated that complex behavior patterns, previously described, do exist in the higher animals. Their work has also led to the discovery of many ways in which instinctive behavior can be controlled and modified. Typically, instincts are interwoven with learned behavior to a greater or lesser extent depending on the past experience or training of an organism. In general, it has been found that the motor pattern of an instinctive behavior is difficult to modify, but the stimulus situation that will elicit a given instinctive reaction is capable of considerable variation.

Modification of the stimulus situation that will elicit a given instinctive behavior pattern can be accomplished fairly easily by repeated presentations of new stimuli in association with the innately determined eliciting stimulus. An example of this can be taken from an early study done by Lorenz and Tinbergen. In this study they were interested in determining which stimulus features of a flying hawk are most important in eliciting the hiding response in young upland game birds (grouse, partridge, etc.). They had previously shown this response to be inborn by hatching the eggs of wild game birds in an incubator, isolating the chicks from other animals, then testing for the hiding response by using a cardboard silhouette of a hawk. The young birds hid under leaves and tall grass the very first time such a cardboard model passed over them in the air, but they did not hide from models of nonpredatory birds. Lorenz and Tinbergen had stretched a cable between two trees so that models of hawks and other kinds of birds could be coasted on a trolley across the open clearing where young birds were feeding. After a few days of observing and recording the responses of the chicks to various cardboard models, Lorenz and Tinbergen found that the birds began to run and hide as soon as Tinbergen approached the tree to attach a model. There had been no tendency to

hide at this time during the first few days, so they concluded that the instinctive pattern of hiding had now become attached to a new stimulus situation—Tinbergen approaching the tree. Subsequent experiments by other workers on species ranging from fish to mammals have verified this conclusion: frequent pairing of a neutral stimulus with the presentation of an innate eliciting stimulus will result in the neutral stimulus functioning as the innate stimulus.

It has also been learned that certain classes of innate response patterns can be readily attached to a wide range of eliciting stimuli during the very early life of some organisms. Imprinting—the phenomenon in which a young animal, if born in isolation, will follow and become emotionally attached to any moving object to which it is exposed at a critical period of development—illustrates this method of modifying and controlling instinctive behavior. In imprinting, the instinctive responses that are normally made toward species members—responses elicited by the mother, and social and sexual responses—come to be evoked by the object or animal to which the young animal was exposed during the critical period for imprinting.

Control and modification of instinctive behavior patterns can also be achieved through the use of drugs and hormones, or through neurosurgical modification of the brain centers which mediate instinctive behavior patterns. In one such study, the administration of a small amount of female hormone directly into a certain area of the hypothalamus, a brain center controlling instinctive behavior patterns, produced spontaneous and well-coordinated sequences of female maternal behavior patterns in male rats. These male rats, who had never had experience with young rats, built nests, retrieved, washed, and even attempted to nurse infant rats. Similar results have been produced for other kinds of instinctive patterns in birds and mammals, using electrical and surgical interference with brain centers.

Under what circumstances might it be desirable to modify instinctive behavior in man? How can this be done?

To most students of behavior this question is irrelevant. As described earlier in this article, members of the psychoanalytic school believe that the basic instinctual demands of the id are constant and that the ego is the agent that channels these demands into acceptable, healthy expression. Thus, all behavior is seen as a modification of these basic instincts brought about by normal ego processes. The behaviorists, on the other hand, deny the existence of instinctual behavior

patterns in the sense in which they are being discussed in this article. For the behaviorists, all behavior is learned, none is instinctive.

But it is apparent from the previous discussion that some behavioral scientists, the ethologists and biopsychologists, are vitally concerned with this problem. To date, these investigators have worked almost exclusively with animals. Their findings have not been developed to the point of application to human beings. As yet, there is no proof that in man there are instinctive patterns of behavior of the type that have been observed and verified experimentally in animals. However, on the basis of their knowledge of instinctive behavior in animals, some behavioral scientists in the ethological movement have speculated provocatively on this question. Lorenz and Tinbergen have hypothesized the presence of several specific instinctive behavior patterns in humans and it is probable that the methods found to modify such behavior in animals would also be effective in human beings.

One man who has concerned himself with the question of ways to modify instinctive behavior patterns in man is John Paul Scott. In his fascinating and provocative short book, *Aggression*, he considers the problem of war. From the perspective of his scientific discipline, zoology, he discusses war in terms of aggression or fighting behavior as it is studied by students of animal behavior. Scott accepts aggression in humans as an instinctive behavior pattern, as it has been shown to be in lower animals. His suggestions for controlling overt aggression in human beings are based on his own extensive research on fighting behavior in mice and other mammals, and on his scholarly review of a wide range of literature on war and violence in human beings, as well as aggression and fighting in animals.

In his book, Scott discusses several obvious commonsense aspects of aggression, the conditions necessary for its occurrence, and ways to control it. Most of these features of aggression have been overlooked by other writers, many of whom have sought to explain aggression in terms of existing theories or prejudices rather than, as Scott has done, attempt to study the phenomenon and its total range of occurrence and expression.

Scott points out that the behavior pattern of fighting is found in all vertebrate species and in each species it takes a fixed, innate form for that species. The conditions which elicit fighting differ from species to species and among individuals within a given species. It is through control of these *conditions* that Scott suggests ways to modify the occurrence of fighting behavior in human beings. These include control

of early experiences in fighting (e.g., not allowing a child to gain practice in responding aggressively); arranging certain kinds of social situations that have been shown in animals to influence the amount of fighting; training not to be aggressive by arranging unpleasant contingencies when aggression occurs; and substituting other vigorous activities when fighting is likely to occur. With regard to animals, Scott lists additional ways to control the occurrence of the instinctive fighting pattern: genetic modification by selection for or against the tendency to fight; administration of drugs and hormones; control of population density, sex ratio, and living space in the environment; and control of the amount of food available. All these measures affect the internal and external conditions that have been shown to influence the readiness of animals to emit the instinctive fighting pattern.

It is Scott's hope that continued study along these lines—considering the instinctive pattern in all its ramifications over a wide range of situations—will increase our understanding and control of aggression, and ultimately of war in human societies. His method of study features a minimum of the traditional arguments against other viewpoints, a restrained and disinterested attitude toward promulgating a theory about the phenomenon, and a systematic examination of all available relevant knowledge and evidence, regardless of its source in terms of the usual categories of knowledge. Scott, a biologist, considers evidence from a wide realm of the fields of human knowledge. He enters his subject with an open mind, avoiding adherence to one or another point of view about the phenomena he is studying. In the discussion of instinctive behavior, where much time and energy has been spent in useless polemicizing, this approach is refreshing, and it has yielded some worthwhile insights into fighting behavior, an instinctive pattern that is important in lower animals and may be present in human behavior. Scott's work on aggression is an example of an instinctive behavior pattern that is of probable importance in human beings, and of ways in which it might be controlled and modified.

Are instincts generally undesirable or troublesome?

Freud's emphasis on conflict between the ego and the instincts in psychopathology, and the popular belief that instincts are, in some ways, animal-like, has often led to the notion that instincts are bad. It should be realized that, in animals at least, instincts have been shown to underlie most social interaction, including such "good" behavior as care of the young, protection of fellow species members, and the recog-

nition and noninvasion of another individual's food-gathering territory.

In general, instincts ensure that the organism will be able to respond adaptively in its normal environment. In many cases an animal must respond correctly to a situation the first time or it will not live to try another response. Instincts may be viewed as behavior patterns which have been "learned" by the species in the course of evolutionary trial and error. Thus, those ancestors of present-day grouse who did not possess a tendency to hide when a hawk sailed overhead fell easy prey to the hawk. They could not reproduce their kind. But the ancestral grouse who did hide lived to reproduce, passing on the hiding tendency to its offspring, if such a tendency were inherited, or instinctive. The advantage of any such inherited tendency is obvious, and the more solidly instinctive this tendency might become, the greater the survival value the species possessing it would have, compared to animals who did not possess such an instinctive behavior pattern.

In times of stress or emergency does one act by instinct?

The belief that instincts can be relied on in solving a tough problem or when quick action is demanded probably results from our inability to explain how such solutions can be achieved without time to think: instinct is posited for want of a better explanation. It is as likely that a quick response, without time to think, may be learned, as it is likely that it may be instinctive. An auto driver's quick action to avert an accident in an emergency must be learned: it is unlikely that an individual who had not learned to drive a car could depend on instinct to manipulate the controls correctly and quickly.

On the other hand, there is indirect evidence that many apparently complex and technical skills, for which human beings are often trained, exist in a rudimentary form in the higher mammals and infrahuman primates. Thus it is possible, for example, that untrained individuals may be able to give valuable aid to badly injured people, since cleaning and pressing together lacerations has been observed as a behavior pattern in wild baboons ministering to wounded species members. Such treatment has impressed the observers as quite sensible and apparently correct in the light of human knowledge about infection and the treatment of injuries.

INTELLIGENCE

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What is intelligence?

Three interdependent conceptions of intelligence recur frequently in psychological writing: (1) ability to deal with new situations; (2) ability to learn; (3) ability to deal with abstractions, with emphasis upon verbal and numerical concepts, but not solely these. Most psychologists specializing in this field regard the third conception as the essence of intelligent behavior, since ability to deal with abstractions enables an individual to transcend the immediate concrete situation, to organize, to analyze and synthesize, to interpret, and to project his thinking into the future. Ability to carry on abstract thinking contributes to a person's ability to adapt to changing conditions, and it facilitates learning. Through the use of symbols and abstract thinking, man is able to extend his horizons and greatly expand his range of behavior and adaptation. The higher levels of intelligence have been well summarized in the following definition: the ability to undertake activities that are characterized by difficulty, complexity, abstractness, economy of mental effort, the emergence of originals, and adaptiveness to a goal.

Are there different kinds of intelligence?

Most psychologists do not hold that there are different "kinds" of intelligence. There are various levels. Ability to deal principally or solely with objects on a concrete level requires intelligence but is not on as high a level as ability to abstract their qualities, understand their relations, and educe correlates. This is the chief difference, for example, between the competent mechanic and the inventive engineer or creative scientist.

In some types of mental activity intelligence must be reinforced by other necessary or desirable attributes. For instance, engineers are helped by a high degree of spatial perception and visual imagery; creative and interpretive musicians must have highly developed auditory perception and recall. Some types of salesmen should have cer-

tain nonintellective personality traits in addition to the necessary degree of intelligence, as herein defined.

How can intelligence be measured?

Intelligence can be measured by means of well-standardized psychological tests. It can also be *estimated* from the quality of an individual's achievement in school, college, or university. It may be *estimated* from the quality of one's work and productions, in terms of the definitions given above.

What is known about the sources of intelligence?

Twenty-five years ago and more, there was a significant difference of opinion among psychologists regarding the relative importance of heredity and of environment in the determination of an individual's intelligence. The controversy was not a matter of armchair speculation; it was based upon different interpretations of research data. A great deal of research was done on this problem, with individuals of all ages from infancy onward, under a variety of conditions: with ordinary siblings, fraternal twins, identical twins, parent-child resemblances; with some siblings and twins brought up together, others reared apart; in their own homes, in foster homes, in adoptive homes of varying cultural quality, and in institutions. The influence of nursery school attendance was studied. The effects of growing up in isolated and culturally and nutritionally impoverished areas were investigated.

For some years now, the view held by nearly all psychologists may be called the principle of interaction: that is, the level of an individual's mental development depends upon the interaction of his genetic (inherited) potentialities (this is a biological matter) with his environment. For the fullest development of one's potentialities, it is desirable that one have an optimal environment that will nurture those potentialities. Environment includes the home, community, school, and other sources of mental nourishment.

Is the general level of intelligence changing in this country?

Some psychologists believe the level is moving slowly downward, but in the United States, evidence for this view is scant and unconvincing. Those who hold this view believe it is so because parents of the lower socioeconomic levels tend to have larger numbers of children than do parents of the middle- and upper-class levels. There is a significant correlation between intelligence and socioeconomic level,

principally as rated in terms of occupations. Hence, it is maintained, genetically poorer parents are contributing a disproportionate share of children. Thus, the general average is being lowered. In Great Britain a large-scale study, made before World War II, provided evidence in support of this view. Other students of the subject maintain that as environmental conditions, including education, improve for all levels of society and sections of the country, the innate potentialities of more individuals will be more fully realized, and the general level of intelligence thus will not deteriorate. (See *Heredity and Mental Health*)

How does the rate of mental development in the United States compare with that of other countries?

There is no evidence to show that rates differ among countries whose cultures are comparable in general. One would not, for instance, compare the growth curves found in the United States with those derived in India or China, because the developmental conditions and the opportunities for intellectual nurture are so unfavorable in the underdeveloped countries. However, even within each country there are segments (subcultures) that differ markedly among themselves, so that to speak of national "rates" or "conditions" can be misleading and can have only general, overall significance. Psychologists speak not only in terms of group differences and similarities, but also emphasize individual differences within each group.

Is the rate of mental development different for various groups? Racial? Economic? Rural and urban?

The rate of mental development of a group will depend in part upon the environmental conditions under which it is nurtured and upon the potentialities of its members. Within each group, however, there are wide variations resulting from the members' individual potentialities.

Extensive research findings with tests of intelligence indicate that certain groups, on the whole, score at lower levels than some others. For example, among those whose average performance is relatively low are children of French-Canadian, Negro, Mexican, southern and southeastern European parents. Some studies also report somewhat inferior average scores of Irish children as a group. Among the groups who score highest are children of western and northern European and Jewish parents. Some thirty or forty years ago the average test scores of chil-

dren in rural areas were consistently below those of children in urban areas. These rural-urban differences have been reduced since rural schools were centralized, educational facilities improved, and opportunities for intellectual nurture in rural areas increased and extended. Children of parents in the higher occupations have much higher average intelligence ratings, as a group, than do those in the lower levels. Offspring of parents in the professions and higher managerial occupations constitute a disproportionately large percentage of superior and gifted individuals in schools and colleges; and the converse is true of offspring of parents employed in the lower occupations (e.g., semi-skilled and unskilled).

Variations in rates of mental development are primarily matters of individual differences, rather than of group membership. There are, to be sure, growth curves for an entire population and for each of the several mental levels within the whole group, i.e., the mentally retarded and deficient, the average, and the superior. These curves, quite understandably, show that the curve of mental development of inferior individuals rises at a slower rate than that of the average group and reaches its maximum at an earlier age. On the other hand, the curve for the superior group rises more rapidly and continues its rise to a later age than that of the average. In varying proportions, individuals from all national, religious, racial, geographic, and economic groups are found at each of the ability levels. Naturally, when a growth curve is plotted for a segment of the population that, as a group, is manifestly inferior, it will show a slower rate of development and its maximum level will not reach that of the average of the population. In this connection, the reader should refer to the discussion of racial differences under *Intelligence Testing*. Psychologists who are interested primarily in the individual, rather than in group trends, do not begin by labeling a person with the general characteristics of his racial or national or economic group.

Are men more intelligent than women?

No, men are not more intelligent. In fact, research with the use of standardized psychological tests shows that girls, as a group, are somewhat accelerated over boys, as a group, in mental development until about the age of six or seven. Several studies have shown a slight female superiority until the age of nine or ten. But the boys catch up, with the result that the two sexes are actually of equal intelligence.

Do men make more use of their intelligence? If so, why?

Men, as a group, do make more use of their intelligence, if the criteria of use are occupations and actual achievement. There is, relatively, a much higher percentage of men than women in all professions, in the sciences, in research, in the humanities, in higher levels of employment in business and industry, in the higher level government jobs, and in music and other fine arts. The disparities between the two sexes, however, are believed to be due to our culture, which discourages or even prevents women from entering these occupations, and to the biological handicaps imposed upon them by childbearing and by their role of mother and homemaker.

Are there more highly intelligent men than women?

In view of the answers to the preceding questions, it is impossible to answer this question definitely in terms of adult achievement. The only finding that is applicable is this: psychological tests of boys and girls, up to the early teens, show that there are proportionately more boys than girls at the extreme ends of the range of mental ability, that is, within the highest 1 per cent of the range of ability and within the lowest 1 per cent. Evidence on this score is not altogether unequivocal, and some psychologists would not agree with this conclusion. The disproportion is greater than would be expected from the fact that the ratio of births is about 105 males to 100 females. It is important to note, however, that the *range* of ability, high and low, is just as great in the female sex as in the male. The practical educational conclusion of studies of sex differences in intelligence is that no distinctions or differentiations should be made on the basis of sex membership alone. (See *Genius*)

Does intelligence alter in the aging process?

Intellectual capacity grows and abilities improve as an individual matures from birth to adulthood. The age at which maximum mental capacity is attained is not definitely known. The best available evidence indicates, however, that maximum capacity is reached not later than the age of twenty-two to twenty-three years. From then onward to the age of forty-five to fifty, it continues on a virtual plateau. A qualification is necessary here: we are talking about basic mental functions that can be measured objectively by means of standardized tests. (See *Psychodiagnostic and Personality Testing*)

After the age of about fifty, a slight decline in these functions be-

gins; the rate of decline increases after age sixty. It must be noted that we are talking of general trends. In some individuals the decline of basic mental functions begins earlier and declines more rapidly than in the general population. In other individuals the opposite is true. Some persons are so superior at their maximum that even after some decline they are still at superior levels. Studies of the ages at which men and women have done their best work and made their outstanding contributions in the sciences, humanities, literature, and other arts show that the decade of the thirties is the most productive in the sciences and mathematics, while in other fields it is the decade of the forties. This does not mean that creative work and production stop then. Also, there are exceptional individuals who continue their distinguished contributions (not necessarily their best) into late life: e.g., Giuseppe Verdi, Thomas Huxley, Francis Galton, Somerset Maugham, Pablo Picasso, L. Tolstoi, Winston Churchill, and Raymond Poincaré (mathematician and statesman).

Curves of mental growth and decline are based upon objectively measurable mental operations by means of standardized psychological tests. These do not measure such intellectual characteristics as judgment and wisdom, which can and often do improve for years after maximum mental capacity is attained. (See *The Aging and the Aged*)

In what ways can certain degrees of intelligence be limiting to an individual?

The first and obvious answer is that individuals who are mentally retarded or deficient are seriously limited in the amount and quality of schooling from which they can benefit, and in the number and levels of vocations they might enter. Also obviously, they are incapable of intelligent participation as citizens and voters, yet many of them vote. (In our complex society this same lack can be seen in people of "average mentality.") Those of retarded or deficient intelligence are more likely than others to become social liabilities (delinquents, unemployed, community charges), either because they are antisocial or, being unable to discriminate and evaluate, are asocial.

A very high level of intelligence might but need not impose handicaps upon a child or an adolescent. He may be bored with ordinary, routine classroom work. In school he may develop the habit of easy success and indolence. He is too old mentally for his own age-group, but he may be too young physically or socially to join a much older age-group whose members are more nearly his peers in mental level.

Children of superior mentality should be dealt with on an individual basis, taking into account each one's degree of physical and social maturation, as well as mental level. (See *The Gifted Child*)

As for adults of superior mentality, their limitations are not so evident, but this much may be said: mentally superior women tend, as a group, not to be satisfied with the career of motherhood and homemaker. Superior persons of both sexes, being more perceptive and insightful, are disturbed much more than others by the conditions of the world in which they live, hence they are more likely to give evidence of neurotic traits in adulthood. Superior individuals generally aspire to higher levels of achievement and have higher standards of performance. They are, therefore, under greater psychological pressure and more likely to experience frustrations.

What relationship does intelligence have to other characteristics of the individual? Insight? Perception? Memory? Personality? Character?

Insight and perceptiveness are themselves elements of intelligence. It follows, therefore, that a person's degree or level of intelligence is indicative of his insights and perceptiveness.

In speaking of memory, a distinction should be made between "rote" and "logical." Degree of rote memory is moderately and positively associated with the level of intelligence: the mentally superior tend to have superior rote recall compared to the average population, while the reverse is true of the mentally inferior. By logical memory we mean the retention of ideas, meanings, concepts, related information, etc. This kind of retention and recall is strongly associated with the higher levels of intelligence. (See *Memory*)

Personality is a very comprehensive term. It includes all aspects of the individual, intellectual as well as nonintellectual. The following statements will refer to the nonintellectual traits of personality.

Contrary to popular opinion, serious personality problems among individuals of superior intelligence do not differ from those of the general population. If there is a difference at all, it is in favor of the mentally superior. Socially desirable personality traits (honesty, truthfulness, dependability, social maturity, etc.) are quite directly related to the level of intelligence. This has been found to be the case with children, adolescents, and adults. Intellectual superiority is not ordinarily accompanied by nonintellectual inferiority; nor is intellectual inferiority ordinarily accompanied and compensated for by superiority—or even mediocrity—in other psychological traits. However, among

persons of average and superior mental ability there is wide variability in all nonintellectual characteristics. Among individuals of almost all levels of intelligence, nearly every kind of difficulty can be found—personality disorders, social maladjustment, behavior problems—but among individuals of superior mental ability, they occur less frequently than in other groups.

The markedly retarded and the mentally deficient present a special problem. The range of variability of their traits is much narrower; their similarities are much closer. They, as a group, have less of everything that is desirable and more of what is undesirable. They are less trustworthy. They are unable to handle most responsibilities of life, although with close guidance and proper training some of them can be useful. Many of the mentally inferior are poor and irresponsible parents. They are often incompetent in their relationships with others. Their maladaptive behavior, which tends to persist, is associated with their mental inferiority. Furthermore, some of the “higher level” mentally deficient individuals (moron and borderline) try to compensate through temper outbursts, physical attack, excessive aggressiveness or (paradoxically) excessive timidity and withdrawal. Higher level deficiencies among children are often prone to develop personality problems as a result of the difficulties they encounter in their attempts to participate as members of a group at home, in school, and on the playground. (See *Mental Retardation*)

Is there a connection between degrees of intelligence and mental illness?

The soundest psychological research on this subject shows that mental illness occurs somewhat less frequently among persons of superior intelligence than in the general population.

What intellectual changes occur in mental illness?

Changes that take place in mental illness depend upon the type of illness. It appears that each type of personality disorder and of mental illness is associated with mental deficits and losses of psychological functioning, but it must be emphasized that the pattern of change in each group is not unique; to some extent losses and impairments are similar among groups, although each also has its own characteristics. For example, in a serious depression, perceptual and associative processes are characteristically impaired, and mental functioning in general is slowed down. In some forms of schizophrenia, reasoning and organized

thinking are seriously impaired, as is the perceptual process, especially in attempts to deal with unfamiliar situations. In some cases, thought content and responses to test questions are stereotyped or bizarre, in others, compulsively elaborate or remote from reality. Ability to recognize and define words suffers less than other functions.

Testing the intelligence of mentally ill persons is a difficult procedure because it is often hard to establish rapport, and at times it is difficult to be certain that the examiner is getting cooperation. The experienced and skillful examiner, however, is able to recognize these difficulties and to reduce the uncertainties to a minimum.

What improvement of intellectual functioning can occur during treatment of mental illness?

The amount of improvement that can be effected in the intellectual functioning of a person being treated for mental illness depends upon the severity of the illness. In general, improvement may be expected if the individual benefits from psychotherapy, or, in less severe cases, if the necessary and significant changes are made in the individual's environment. Recent studies indicate that the more favorable the initial "picture" is, as revealed by various psychological tests, the better are the prospects for subsequent improvement. In the cases of improved individuals whose test findings parallel clinical improvement, their overall mental functioning improves, especially in reasoning and ability to deal with practical problems; they become more objective in their thinking; and their perceptiveness improves. In the cases of persons whose condition grows worse, the changes on tests are in the opposite direction.

What are the significant areas of current research into intelligence?

Since the end of World War II, psychologists, in general, have been devoting vastly more attention to studies of personality, clinical problems of diagnosis and treatment, and aspects of social psychology (e.g., "small group" behavior, prejudice, measurement of attitudes and opinions, and cross-cultural studies of child behavior) than they have to the research on the subject of intelligence. Currently the areas most frequently investigated are these: identification by statistical analysis of the components (or factors) of intelligence—such as word fluency, verbal meaning, numerical facility, inductive and deductive reasoning, memory, and spatial perception; determination of the combinations of components necessary for each of a variety of types of education and

vocations—such as academic, engineering, mechanical, clerical, fine arts, law, and medical; determination of the components of “creative ability”; attempts to improve the intelligence of mentally deficient children by means of drugs (quite unsuccessful thus far); and intellectual changes in old age. The improvement of intelligence tests themselves is a matter of continuing interest and research. All of the foregoing areas of research are motivated by interests in psychological theory, and basically also by concern with the more accurate analysis and description of human abilities and their more nearly optimal utilization, not only for society’s sake, but also for the sake of the individual. (See *Creativity; Aptitude and Vocational Testing*)

INTELLIGENCE TESTING

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How is intelligence tested?

Intelligence is tested by means of "scales" that have been standardized on a scientifically selected sampling of the specified population for whom the test is intended. The test may be devised either for a relatively narrow or for a wide range of ages.

By a scale we mean a test that progressively increases in difficulty. The author of a test of intelligence bases its construction upon an accepted definition of intelligence and upon analyses of mental operations, or functions, that have been widely accepted by psychologists as a result of research and experiment covering a period of many years.

How are the reliability and validity of intelligence tests determined?

In the process of standardization, the author of a test must establish: (1) its reliability, and (2) its validity. A test is reliable if it yields highly consistent results on repeated testing and if the results obtained at a given time are dependable. There are several statistical techniques for establishing reliability. It is valid if it measures what it purports to measure.

There are several types of validation, the two most important being "construct" validity and "predictive" validity. If a test has construct validity, it measures concepts, or elements, of intellectual behavior that are significant in mental activity (e.g., facility with quantitative materials, knowledge of word meanings, ability to discern relationships, etc.). This form of validity is a matter of judgment by experts on the content of the test. Ultimately, all tests of intelligence must prove their predictive validity, that is, they must be shown to be valid predictors of external criteria: for example, extent and quality of education of which one is capable, and most probable occupational level one might aspire to.

What are the various types of tests?

There are individual tests and group tests. The former are administered to one person at a time; the latter may be administered to groups, small or large.

Some tests utilize only verbal and numerical content; others include, also, nonverbal pictorial materials. For persons who are handicapped by language disabilities because of sensory defects or because they are non-English speaking, there are "performance tests." These utilize a variety of types of materials, including drawings, blocks, disassembled pictures (similar to jigsaw puzzles). But all types of intelligence tests presumably sample a number of the mental functions generally accepted as the constituent elements in the operations of intelligence.

Is it intellectual ability or intellectual capacity that is tested?

Capacity is defined as the power of containing, or absorbing, or developing. In psychology, capacity is distinguished from ability, which signifies that the specified operations or tasks can be performed now. The two terms are not used interchangeably in technical psychology but, actually, they are not separable. They are two sides of the same coin. A test of intelligence is intended, primarily, to measure the individual's capacity to learn, to benefit from training and experience, and to perform certain specified tasks. That is, the test is a measure of his potentialities (capacity). However, since intelligence can be tested only in terms of what an individual is able to do at a given time with regard to certain mental operations, his ability, as of the time of testing, is being evaluated. Thus his ability, at a given time, to perform certain mental operations is evidence of his capacity in both the past and future.

Has such testing any purpose aside from determining an individual's intelligence quotient (I.Q.)?

Whenever an intelligence test is given, whether to one person or to a group, there should be a definite purpose for doing so. The I.Q. is an index of the individual's rate of mental development compared with that of his age group. It is also defined as an index of his degree of brightness (or dullness). In order to find the I.Q. it is necessary, with many but not all tests, to derive a mental age (M.A.). This index shows the individual's mental level at the time of testing. Is he at the eight-year level (M.A. = 8)? At the twelve-year level (M.A. = 12)? Etc. Thus, a test may yield not only an index of rate of mental development

(I.Q.), but also an index of the level attained at a given time (M.A.). The testing of adults and of selected groups, such as prospective college students, presents special problems, so that I.Q. and M.A. are often not used with them.

The professionally competent psychologist who gives an individual test of intelligence is concerned with finding more than an I.Q. or M.A. He analyzes the test results to discern strengths and weaknesses, consistencies or inconsistencies in performance, the qualitative aspects of responses (richness, variety, imagination, verbal facility, precision, self-criticism, etc.) as well as to find a numerical rating. He observes the individual during the examination for evidence of handicapping emotions or attitudes; he studies the responses for evidence of bizarreness and other symptoms of possible personality disorder or of less severe but handicapping personality traits. The qualified psychologist, after the formal examination is finished, will at times conduct an interview with the examinee in order to learn more about the nature of and reasons for some of the responses. All of this goes into the report. This is the clinical procedure in testing.

This procedure obviously cannot be followed when group tests are used, although for certain individuals who have taken group tests the examiner can make comparisons among scores on the subdivisions of the scale in order to find the individuals' strengths and weaknesses, consistencies and inconsistencies.

When did intelligence testing begin and what is its history?

It is difficult to set an exact date of the beginning, because a number of types of psychological research and educational problems led to and crystallized research directed definitely toward testing individual differences in intelligence. It can be said, however, that the history of modern testing dates from the early 1880's when Alfred Binet, in France, began his intensive studies, which lasted until his death in 1911. Psychologists in other European countries and the United States did a great deal of research between 1890 and 1910. The first formal scale, however, was Binet's in 1905. He published revised versions in 1908 and 1911. His 1908 scale was first used in the United States, at the Vineland (N.J.) Training School in 1909.

The first standardized test adapted for use in this country was published in 1916. It is known as the Stanford Revision of the Binet-Simon Intelligence Scale, and is an adaptation of Binet's scale. It got its name from the fact that Lewis M. Terman, the senior author, was a member

of the department of psychology at Stanford University. Two revisions of this scale have since been published: one in 1937 and the other in 1960. The other very widely used individual scale is the Wechsler-Bellevue Intelligence Scale, for adolescents and adults, published in 1939 and revised (1955) as the Wechsler Adult Intelligence Scale. In 1949 the Wechsler Intelligence Scale for Children (sixteen and younger) appeared.

The first group tests in the United States were the Army Alpha (verbal and numerical) and the Army Beta (nonverbal), developed for use in World War I. These were developed from materials on which a number of psychologists had been doing research prior to the war. After 1918 a large number of group tests of varying merit were published, among them being instruments for use at all ages from the kindergarten level through adulthood. Beginning in the 1920's and continuing to about 1940, scales for infants and preschool children were developed.

Nonverbal, performance type standardized tests first appeared in 1917, although this type of test material had been used in juvenile courts in a preliminary and exploratory way as early as 1910.

Beginning in the mid-1920's and accelerating during the 1930's, group tests for college students were constructed, from freshman to senior level. Some of these are called "scholastic aptitude tests," or "analogies tests," or "concept mastery tests," but all are essentially tests of those aspects of intelligence most important in college and university work. Thus there are today a few individual tests and many group tests for all ages and educational levels.

What training is required for the interpretation of tests?

An answer to this question depends upon the type of intelligence test we have in mind, that is, group or individual tests. To make competent interpretations of group test findings, one should have at least a master's degree, or its equivalent, based upon a course of study primarily in psychology, including work at the advanced level in the area of test theory (psychological and statistical) and testing practice. The master's degree should be followed by at least a year of practical experience "under supervision."

Administering and interpreting individual scales, such as the Stanford-Binet and the Wechsler, require much more preparation and practice. Although one can be prepared at the master's degree level to work as a competent technician, this is insufficient if the examiner is to do a high-level professional job. The Ph.D. degree, or an equivalent, is

highly desirable and is now one of the requirements in many states where a license or certificate is necessary for the private practice of psychology. The Ph.D. preparation will include the study not only of tests and testing, but also of advanced work in various basic aspects of human behavior, such as motivation, emotion, personality development and organization, individual differences, abnormal behavior, and learning theory. Completion of graduate study for the Ph.D. should be, and generally is, followed by at least a year's experience under supervision, even though in this area graduate study itself usually involves considerable laboratory and clinical practice. Administering individual tests and interpreting the findings is essentially a clinical procedure with which only highly qualified professional persons should be entrusted.

How extensive is testing in schools in this country?

Group testing of intelligence and of subject-matter learning (educational achievement tests) is widespread. It would be the unusual school system where this is not the case. Testing with individual scales, however, is not common except in larger cities that have guidance and counseling divisions, or in more progressive, wealthier small cities. It is unfortunately true that too many individuals doing individual testing in public schools have had inadequate professional preparation.

Does intelligence testing reveal any differences in the intelligence of males and females?

No. The notion that such differences exist is a discarded bit of folklore. It appears, however, that there are somewhat more males than females at the very extremes of mental ability (mental deficiency and mental giftedness), but the reasons for this, if it is a fact, are unknown. (See *Intelligence; Genius; Creativity*)

Are intelligence tests accurate?

There are several aspects to the answer. If a test is reliable, it measures accurately what it is measuring. If a test is valid, it is satisfactorily measuring what it purports to measure. In any individual instance, however, the results obtained with an intelligence test might be adversely affected by strong emotions, personality disorders, behavioral problems (e.g., hostility, lack of motivation), or a seriously impoverished early environment. The qualified psychologist who gives an individual test, when interpreting test results takes into account the

available background information on the person tested, and is sensitive to and perceptive of disturbing conditions or personality factors that might be effective during the testing. When group tests are given, it is very difficult or not even possible to make such observations of individuals, although background information can be used.

It is not correct to say, however, that test findings obtained under adverse conditions, such as the foregoing, are not accurate. They are accurate if they represent the individual's level and quality of mental functioning as of a particular time, though these findings may not be indicative of his ordinary and normal functioning under optimal conditions. To use a medical analogy, if a person has suffered an ailment that had harmful but curable effects upon the condition of his blood, the abnormal condition of his blood does not make the blood analysis inaccurate.

What is the present state of testing in other countries?

Tests of intelligence are in use in Canada and in most countries of Western Europe. They are also used, to some extent, in some Asian countries: e.g., India, Japan, and Nationalist China. There is some interest in testing in a limited number of South American countries: e.g., Brazil and Chile. It is probably a fact that individual testing of intelligence—in schools, guidance centers, mental health clinics, and in private psychological practice—is much more widely done in the United States than elsewhere.

There is considerable interest and research in this branch of psychology in some other countries, particularly in Great Britain and the Scandinavian countries.

Can the intelligence of primitive peoples be tested?

The intelligence of primitive peoples cannot be tested with the instruments we use. Entirely new and separate tests would have to be developed for each group of primitive peoples. Such a project would not only be extremely difficult, but should not be attempted until illiteracy has been considerably reduced and elementary schooling, at least, has become widespread among the primitive peoples.

How early in life can a child's intelligence be tested?

Scales are available for testing the psychological development of infants at ages as young as two months. These scales for infants, however, do not probe and sample the same mental processes as do those

used with individuals who are two years of age and older. Infant scales test the level of development of sensory and motor capacities, beginnings of language, and awareness of and responses to other persons. Results obtained with these scales before the age of eighteen months or two years have little value for the prediction of later mental ability except in the case of children who test at markedly superior or inferior levels.

Can an individual's I.Q. change during his lifetime?

There are several aspects to an answer to this question. If a child has been living in an intellectually impoverished environment (this means more than a poor home) from birth or early childhood, it is probable that his performance on a test of intelligence will suffer. If his environment is significantly improved at a relatively early age (as early as possible, but before the age of ten), his I.Q. will rise if he has the capacity to benefit from the new environment. The extent of improvement will depend upon his innate capacity, the age at which he was placed in the new environment, and the length of time he stays there.

Some of the measured mental abilities decline a little during middle age, but decline more so in old age. Thus the I.Q.'s of these older persons in absolute terms will be lower than when these persons were at their best; but individuals tend to maintain their same relative ranks among their peers, unless they are affected by mental illness or certain physical illnesses.

Any person's performance on an intelligence test could be lowered by physical illness or emotional disturbance. When this happens it is not a "change" in the I.Q. It should be regarded only as a temporary state due to conditions that are remediable. The qualified psychologist always takes into account the examinee's physical condition as reported to him or as he observes it. He also takes into account the emotional condition, which he will be aware of from other sources of information, or which he is able to observe during the examination through the examinee's overt behavior and physiological reactions (e.g., blushing, stammering, excessive fidgeting, sullenness, hostility, inattentiveness), and often through the test responses themselves.

Can the examiner influence the results of a test?

The personal qualities, the professional skill, and the attitude of the examiner are factors in testing an individual. The examiner must

maintain a balance between friendliness and professional objectivity; he must know when to encourage, when to continue or not to continue. It goes without saying that the examiner must have the techniques of testing at his fingertips. Many studies have proved that when two or more well-qualified psychologists examine the same individuals, they obtain practically identical results.

What use do schools make of an individual's I.Q. rating?

In elementary schools, the pupil's I.Q. ratings are used for sectioning according to ability, that is, arranging more nearly homogeneous ability groupings, which facilitates differentiated instruction. The test findings are also used to help determine whether each pupil is achieving at a level consistent with his ability, or whether in some cases pupils are in schoolwork that is too difficult for their capacities. At times, intelligence test results will provide insights into the reasons why some children are problems in the classroom: for example, the child of superior intelligence who is bored by the slow pace and repetition, or the dullard (or the mentally deficient) who is mystified and compensates by making a problem of himself.

In high schools—junior and senior—the tests are used for the same purposes as in the elementary school and, in addition, for educational guidance. Intelligence test ratings do not indicate the type of occupation a pupil should prepare for. They do serve, however, as limiting instruments in that they indicate the most probable level of occupation to which a pupil should aspire. The test findings also serve to indicate the types of high school courses and curricula best suited to each pupil. (See *Aptitude and Vocational Testing*)

Who should be informed of a child's I.Q. rating?

Psychologists believe that giving out information on an individual's I.Q. is unwise, because these indices are too easily misinterpreted and they can become symbols and criteria of undesirable comparisons. When a parent has to be advised in regard to a child's mental capacity, descriptive terms (average, somewhat superior, lacking in academic capacity, etc.) should be used, rather than number ratings. Teachers often have to be informed of the intelligence test ratings of their pupils in order to better understand their learning capacities, but unless teachers are instructed in the interpretation of test results, it is wiser to give them indices of levels: average, highest 5 per cent, lowest 5 per cent, etc.

Can there be any sound reason why an individual should not know his own I.Q.?

The reasons against giving the individual this information are the same as stated under the preceding question. Each pupil, however, can and should be advised in regard to his best educational prospects, accentuating the positive aspects, without giving him a numerical rating.

How are mentally retarded persons classified according to test results?

The commonly accepted classification is the following: 80–89, dull or retarded; 70–79, borderline defective; 50–69, mentally defective (moron group); 25–49, imbecile group; below 25, idiot group.

What is the test for determining mental retardation in children?

Any one of several scales may be used for this purpose. The choice of the one to be used depends in part upon the individual's age and degree of retardation. Whenever a diagnosis of suspected retardation is the problem, an individual scale should be used; generally, either the Stanford-Binet (down to age two) or the Wechsler scales (from age five upward). For children under two years of age there are several, notably the Cattell Infant Intelligence Scale, and the Gesell developmental schedule. At times, it is necessary or desirable to supplement the first two, above, with a performance test (which uses objects rather than verbal materials) as confirmation.

What is the test for determining mental retardation in adults?

The one most frequently used is the Wechsler Adult Intelligence Scale. The Stanford-Binet is also widely used. Performance tests are used for confirmation. In addition, some psychologists like to use the Rorschach inkblot test which, though it does not yield a mental age or I.Q., can provide information from which inferences may be drawn regarding the examinee's mental operations.

Does the score alone determine whether the retarded individual is educable or trainable?

Although the overall score is significant, the well-qualified psychologist makes a qualitative analysis of the individual's responses, looking for evidence that might be either contrary to, or in support of, a diagnosis of retardation. The examiner takes into account, also, as much of the

individual's history as may be available: home background, quality of parents, school history, emotional status, sensory and physical handicaps, and developmental history. (See *Mental Retardation*)

Can testing be misused in its present applications?

Psychological testing—like medicine, law, or any other professional practice—can be misused in the hands of incompetent practitioners or in those of nonpsychologists. All persons—teachers, school administrators, personnel directors, physicians, and especially psychiatrists—who use the findings and reports of testing have an obligation to learn enough about tests and testing so that they will be capable of insightful understanding of the information given them by examining psychologists. Fortunately, many states now have statutory licensing or certification requirements; many school systems are raising their requirements for school psychologists. In states where there are no statutory requirements, some of the psychological associations issue their own certificates and the American Psychological Association conducts examinations for certification of diplomas in the several branches of psychological practice. (See *Psychodiagnostic and Personality Testing*)

Where are intelligence tests given outside of school systems?

They are given in mental hospitals, veterans guidance centers, mental health clinics, private welfare agencies, prisons and correctional institutions, in private psychological practice (for diagnosis in conjunction with psychotherapy and for educational and vocational counseling), in business and industry, by civil service and other governmental agencies, by colleges and universities, and in the armed forces. Tests are used in various types of research in psychology, sociology, psychiatry, and anthropology.

Are there further uses of testing that might benefit education or community life?

The use of psychological tests should be strongly discouraged except for well-defined purposes, and the administration of such tests should be entrusted only to well-qualified psychologists.

In addition to the uses already listed it has been suggested, not altogether facetiously, that intelligence tests might be used for two other purposes: as a prerequisite to the privilege of voting (requiring a specified minimum rating); and as a prerequisite to naturalized citizenship,

unless, in either instance, other valid evidence is available (e.g., a college or university degree, holding a high-level job, or practicing a profession). However desirable these practices might be to improve the mental quality of the electorate, they do not seem to be feasible for reasons quite apparent.

JUVENILE DELINQUENCY

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What is juvenile delinquency?

To some people juvenile delinquency is the behavior in young children and adolescents of which they disapprove. To others, it is everything reported to and dealt with by police, courts, and attendance officers, insofar as it involves young people. Technically, juvenile delinquency is the behavior adjudicated by a court, in accord with the laws of a given state.

In general, statutes tend to include as delinquency two types of behavior: (a) that which would be a crime if committed by an adult; (b) that which is not criminal in adults but is specifically forbidden for children: truancy, incorrigibility, and being beyond the control of parents or guardians, as well as immoral conduct, use of obscene language, etc.

What is the juvenile delinquency age?

This depends on the state statute. The upper age limit for juvenile court original jurisdiction is most often eighteen, but some states set it at seventeen and a few at sixteen years. In some instances those over eighteen may be transferred to juvenile court at the discretion of a criminal court. In a few instances there is original jurisdiction up to twenty-one years of age. A considerable amount of jurisdiction is shared with criminal courts in the most serious offenses—the exact age varying with the state.

The National Council on Crime and Delinquency (headquarters in New York City) and the United States Children's Bureau recommend exclusive juvenile court jurisdiction in cases up to the age of eighteen. This is the situation in federal courts.

How many juvenile delinquents are there?

The answer depends on definitions. Studies show that many young people engage in acts which would—if reviewed in court—justify ad-

judication. Similarly many adults break the law but are not detected, accused, or tried. Only a small portion of "potentially adjudicable" delinquency reaches police, courts, or any potential petitioners of the court.

Some delinquency statistics list all those who are reported to police or courts, but this is hardly appropriate since a large proportion of these cases are trivial or are discharged for lack of a legal case.

The question is best answered by referring to the juvenile court statistics of the United States Children's Bureau. These have been assembled in relatively systematic and comparable fashion for some time. If we exclude traffic offenses, we find over half a million juvenile court cases a year, involving approximately 450,000 (different) children between the ages of ten and seventeen.

What are the chances that a given child will become delinquent?

This is not precisely known. If traffic cases are excluded, the rate for a given year is about two per hundred children. In some cities it reaches three or four per hundred.

However, there are subareas in large cities in which the rate is ten, fifteen, twenty, or thirty per hundred children.

There are major rate variations by type of geographic area (urban rates are two and a half times rural rates), of economic background (far more children get to court from impoverished slum areas), and of social-ethnic background (certain underprivileged minority groups are overrepresented, but not all).

The rate does not describe adequately the chances that certain children will be known to the court during the course of their childhood or adolescence. Incomplete answers come from a few studies in large cities. It appears that in some of these, one boy in five will reach court before his eighteenth birthday. The rate for girls is much lower. Boys in certain highly disorganized neighborhoods or of given population subgroups have even higher "chances" of court appearance.

In general, boys outnumber girls in court at the rate of about four to one.

Is delinquency increasing?

In considering delinquency trend statistics it is necessary to allow for the possibility that increases are due to better reporting or detection, that definitions are changing, that court adjudication policies are changing, that records are improving, and so on. Nonetheless, taking

all of this into account, it is reasonable to state that more delinquency cases are getting to the court than did before World War II, and that they reflect more delinquency cases within all official channels.

Specifically, based on systematic uniform juvenile court reporting, the United States Children's Bureau concludes that delinquency case totals have increased annually for the past dozen years. Moreover, with the exception of one year, the increase far exceeded the population increase.

In what sense is delinquency a mental health problem?

The mental health field is concerned with adjustment, social productivity, adequacy of interpersonal relationships, integration of personality, mastery of environmental challenges, adequacy of perception of reality, and similar criteria. Children who reach the courts tend to have problems in several of these areas and are often quite anxious, tense, unhappy, hostile, or confused.

What is known about the social backgrounds of delinquents?

In *Unraveling Juvenile Delinquency*, Sheldon and Eleanor Glueck compared institutionalized delinquents with "controls" from the same underprivileged neighborhood. In general (and with many exceptions) the delinquents came from families which moved about more often, lived in more crowded and filthier homes, and were of a lower economic status. Their parents were less skilled in labor-market terms, had lower incomes, and were more often from broken homes. Again, with many exceptions, parents of delinquents were more likely to be burdened by serious physical problems, mental retardation, emotional disturbance, and criminal records.

Bernard Lander, in *Towards an Understanding of Juvenile Delinquency*, concluded with the finding that areas of "normlessness" (lacking value stability and integration) and economic disadvantage produce high rates of delinquency.

While many of the existing studies tend to limit themselves to unrepresentative populations and do not distinguish between describing and explaining delinquency, the accumulated evidence in the descriptive realm is relatively consistent. Delinquents usually come from impoverished, disorganized, changing neighborhoods, and from broken or disrupted family backgrounds. Many derive from ethnic or social backgrounds in which the family, as it is generally defined on the American scene, does not exist and often has never existed. Many delinquents are

cast out by, or emancipate themselves from, their families at a very young age and are not subject to parental discipline, control, or precept. They often live in neighborhoods in which there are few social controls and moral standards that might inhibit antisocial activity. Indeed in recent years a group of scholars have shown that the family and other primary institutions are replaced as sources of standards, values, goals, and behavior for these young people by a so-called "delinquent subculture" that is transmitted in some neighborhoods in antisocial peer groups.

Within middle-class groups there is a significant amount of law breaking and other unacceptable conduct, in terms of juvenile court statutes. However, much of this is suppressed and handled informally within the family, the church, private psychiatric resources, and private schools. Its exact extent is unknown. Most experts seem to agree, however, that the rate of antisocial behavior is higher in lower-class groups of the slum areas. All that is certain is that many other children from the lower-class groups are dealt with by police, courts, state institutions, and probation services.

While urban delinquency rates are far higher than rural and suburban rates, the rise of rural and suburban delinquency in recent years has caused interest and concern.

A final observation must also be made about the social context of delinquency; much of it is a group phenomenon. Some delinquents are "loners"; many commit their offenses in the company of others. Since definitions, detection, reporting, and adjudication are dependent on many factors, it is no surprise that there are no reliable estimates as to exactly how much of the reported delinquency is a group phenomenon. Many current programs of prevention and control assume that a very substantial portion is.

Why do gangs command such strong group loyalty?

Most adolescents "gang" for mutual support in the difficult transitional period to adulthood when they are no longer able to lean on their parents as children. In areas of poverty and disorganization the gang is particularly meaningful, because harassed and under-equipped parents give up, and the feeling of aloneness may be thereby increased. Albert K. Cohen and other experts (Lloyd Ohlin, Richard Cloward) have also suggested that lower-class boys, lacking access to the broader opportunity structure of middle-class society or lacking skills for making their way, use their gangs as sources of hedonistic satisfaction and

to attack the controlling powers in a nihilistic and profitless way. Thus the delinquency is often quite violent and purposeless. Some gangs are entry points to racketeering society and avoid random fights and conflicts. Others, meeting blocking action on all fronts, retreat to drugs. Still other gangs are built around the personality disturbances and pathology of their leaders.

Most delinquency is gang delinquency but most gang members grow out of the experience as they move toward their twenties—unless caught in the rackets or in narcotics, or subject to personality problems that motivate deviant behavior.

What is known about the intelligence of delinquents?

A little more than a generation ago, authorities were convinced that most delinquents were of borderline intelligence—or less. Current studies agree that reported delinquents represent a range and distribution of intelligence scores typical of children in the social and economic environments from which they come.

However, since a large portion of the delinquents who reach courts, police, institutions, and detention, come from the most deprived areas of cities, it is not surprising that large portions of delinquents are retarded in reading and other fundamental learning skills.

In fact, deprivation, disorganization, lack of social opportunity, lack of knowledge of the English language, low intelligence scores, and detected and reported delinquency, are all interrelated in a complex pattern. Since to a considerable extent, delinquency is a matter of how society notes and defines “deviance,” some of it may be synonymous with the enumerated handicaps and lack of skills.

What is known about the physiques of delinquents?

Very little. Few authorities believe today in “physical types” that are predisposed to delinquency.

In the most careful recent work on the subject, the Gluecks report an excess of mesomorphic body types (a rather energetic, athletic body type) among delinquents; they speculate that these physical traits facilitate delinquent activity in a difficult sociocultural environment. They caution against seeking any unit cause of delinquency such as physical type and suggest instead, in an interesting group of hypotheses, that “body type” is one of the variable factors in the complex clustering, out of which emerges the behavior labeled as delinquency.

What is known about the psychiatric status of delinquents?

When alleged or adjudicated delinquent children are studied psychiatrically in courts, detention homes, or institutions, a considerable proportion are found to have classifiable psychiatric disturbances. While there are few psychotics, the following diagnoses frequently occur: primary behavior disorder, character disorder, adolescent reaction, psychoneurosis, and schizoid personality. The exact proportions vary with the age groups, locale, and psychiatrists represented.

This fact has resulted in a tremendous emphasis on the need for psychiatric evaluation and treatment of delinquents wherever they are dealt with. In a sense, the history of services to delinquents in the period 1945 to 1960 is the history of attempts to assure an adequate psychiatric component in programs. The psychiatric, psychological, and social work literature has considerable material about delinquents, and particularly in the recent past, some segments of these professions tended to go to the extreme. The latter saw delinquency as a psychiatric problem, occasionally even as though it were a coherent, unified psychiatric diagnosis, and minimized all except psychiatric help. Practitioners and students of the problem now feel, along with the author of this article, that the identification of a psychiatric problem in a delinquent does not necessarily tell us anything about the delinquency. It may be that the psychiatric problem is not associated with the delinquency and that, in dealing with the delinquency, the community need not concern itself with emotional problems uncovered by comprehensive study. Treatment of the psychiatric problem may not necessarily affect the delinquency. We do not do mass psychiatric screening of the public and then treat all those diagnostically classifiable. Rather, we await the development of problems in social functioning or personal feelings traceable to psychiatric difficulty.

Is there any way to characterize delinquents generally?

No, only that they are children and youths, adjudicated as such under the statutes of a given state. Indeed, if it were possible to legislate changes in language we would urge that people talk not of "delinquency" but of the "delinquencies."

There are many delinquencies. To suggest a few:

- 1) Sometimes what is called delinquency is a matter of a child's learning, incorporating, and practicing the values, attitudes, and behaviors that characterize his family, his peer group, or his

neighborhood, but are not acceptable to the public at large. His internal personality problems, if any, do not enter.

- 2) Sometimes what is called delinquency is the direct consequence of, or is symptomatic of, one of many possible kinds of personality disturbance, as in the instance of the kleptomaniac, arsonist, or school phobic who is truant.
- 3) Sometimes the delinquency is a transitory, if very troublesome, pattern resulting from the complexities of the "adolescent crisis."
- 4) Sometimes the delinquency combines several elements, as in the instance of some drug addicts who live in the midst of a racket group or antisocial group, but who themselves withdraw via drugs as the result of a personality disturbance.
- 5) Sometimes the delinquency is not at all what would be considered criminal behavior in adults, but is a parent-child problem brought into the public domain because of (a) the parental subculture and its ways of using authority; (b) parental emotional disturbance.

What, then, is the cause of delinquency?

What is identified and dealt with as delinquency varies by social class, ethnic group, geographic area, city size, educational level, and many other factors. In an extreme sense, then (and avoiding the real intent of the question), delinquency is "caused" by the decision at a given time and place to deal with certain child-and-youth behavior through certain channels.

And even among the phenomena included under the delinquency "umbrella," there is no one cause. Theories that list one cause are suspect. There are many patterns and subpatterns causing delinquencies. One of the types is the outcome of the interplay of a variety of factors in a complex causal network. In a sense, the "cause" we are concerned with at a given moment may be defined by the level on which we wish to intervene with the process—broad social scene, local community, peer group, family, social skills, personality, behavior, and so on.

Are parents responsible for the delinquency of their children?

In several senses, yes. Delinquency is a failure in socialization, in development of values, and in the response to social controls. It may reflect lack of skills or goals basic to successful adjustment. It may reveal lack of exposure to ethical and moral standards. Parents are the

prime source and introduction to all these. Parents are also legally responsible for their children.

Yet parents are often the victims of the same disorganized circumstances and forces to which they subject their children. Lacking opportunity for achievement and wanting in skills and resources, they may not be able to open opportunities to their children or to seize what is available. Or, being mentally defective and emotionally insecure and disturbed, they may involve their growing children in emotional problems and tensions that are reflected in delinquent behavior. Some psychiatrists have identified cases in which parents act out their own emotional problems through their children, whom they have reared with "superego lacunae" (gaps in conscience).

Parents who are not disabled, defective, or disturbed can do much if they assert their responsibilities and intervene—often as a group—in shaping community standards for youth and in opening sources of wholesome experience.

Do we know how to prevent delinquency?

To some extent, but again the answer depends on definitions.

The ultimate prevention of delinquency—or what the public health person calls "primary prevention"—is both as vague and as difficult as promoting "the good life." However, the roots of delinquency are clearly to be seen in: public and private values, goals and morality; the state of international affairs and their ramifications in community, family, and personal lives; the extent to which churches, synagogues, and other sources of values do or do not affect the public outlook; the ways in which industrialization, urbanization, automation, internal migration do or do not contribute to opportunity, do or do not strengthen sound primary group relationships, do or do not permit youth to develop with a sense of purpose, and so on. Hence, one does not actively work to prevent delinquency. Broader goals and values are involved.

By prevention, some people mean "secondary prevention," the early identification of the vulnerable and those showing developmental problems, and the provision of helpful services and experiences. While the evidence is by no means conclusive and one-sided (and by its very nature is difficult to accumulate), there is basis for the view that:

- 1) We do know something about how to interpose positive forces, experiences, and influences between deprived, vulnerable, high-risk children and their social environments, so as to decrease the likelihood of ultimate delinquency; for example, through special

cultural enrichment of school programs in deprived areas and special vocational training opportunities.

- 2) We do know how to offer individualized and group services to children who have various habit and conduct disorders, or whose associations are leading them into trouble (with a high degree of probability), and to decrease the likelihood of the trend's continuation until it leads to the court; for example, through clinical programs, group programs, settlement programs and detached gang workers.

To some people prevention of delinquency means deterrence and control. Here the assumption is that the individual will violate the law if he can, but that police and courts could stop this course of conduct. Apprehension and arrest are the main techniques. This is, of course, an essential public provision but does not constitute prevention in the sense generally meant.

There is also what the public health expert calls "tertiary prevention." In this instance we refer to the treatment of delinquents to avoid continuation or repetition of the pattern. This is more appropriately discussed in connection with the various forms of service.

Do we know how to predict delinquency?

Several groups of experts are working on the problem, but there does not yet exist a device or instrument which is known to be highly reliable (all users obtain the same results), valid (able to obtain the desired result), and usable in normal (nonexperimental) circumstances. Some of the methods involve tests and checklists. The Glueck scales, the best known, require judgments by highly trained social workers on home visits.

In general, the available devices—particularly the Glueck scale—are highly successful retrospectively, i.e., when applied to known delinquents in institutions, etc., they yield scores indicative of delinquency. There is as yet inadequate predictive research. Only such research will tell (a) how many future nondelinquents are inappropriately labeled as delinquents by the devices; (b) how many future delinquents are missed. There are differences of opinion about the matter, but the author of this article expects the ultimate finding that even some of the best known scales overpredict delinquency among those who do not become delinquent.

Labeling a child as "delinquency prone" or as a potential future delinquent sets in motion a chain of circumstances that may lead him to

be treated in undesirable ways (ways that may in turn "cause" delinquency). Hence some people favor the development of scales and devices to identify children who need special services or help—but not the use of delinquency prediction instruments. Some would stress identification of city neighborhoods, not individuals, as needing many preventive and rehabilitative services. Others would develop prediction instruments for research purposes in order to test theories of delinquency, but not for general operations. Still others would develop them, restricting their use and their results to professionally qualified persons.

If delinquency prediction scales are not to be used, how are children to be identified for prevention and early help?

First, the evidence is impressive that teachers are highly effective case finders. If they were helped to evaluate what they see and had resources on which to draw when needed, early identification and effective intervention would be substantially assured. (See *Schools and Mental Health*)

Second, those missed by teachers in the early grades are encountered under circumstances permitting adequate case finding by some of the following: doctors, public health nurses, public welfare workers, settlement workers, police, clergy, and many others. This personnel may need some further preparation, to sharpen perceptions, assist in decision making, and guide the channeling of situations requiring community follow-up.

Experts who stress the development of delinquency prediction scales and instruments, more than does the author of this article, tend to agree that early identification in daily school and community routines is actually not difficult. They wish, however, to assure and routinize the process and the next steps.

What specialized agencies, services, and social institutions are needed in a typical community in order adequately to cope with those alleged to be delinquent and those found to be delinquent?

In brief outline form, a community requires:

Juvenile aid police or a police youth bureau—to apprehend offenders where necessary, to prevent or stop gang fights, and to evaluate and sort out the many complaints that arise. They are called upon to choose from among the several major decision possibilities: court re-

ferral, referral for help in a community agency, advice and warning to parents, and so on.

Juvenile detention facilities—to provide secure care pending court disposition (or between the time of court disposition and transfer to a long-term facility) for those who cannot be returned home after arrest or the swearing of a court petition. Children need detention if their return to the community involves (a) hazard to themselves; (b) danger for the community or for others; (c) a high probability that they will be removed from the area of court jurisdiction.

A juvenile court, children's court, or family court—to determine in a noncriminal tribunal whether the act or offense alleged has actually occurred, and then to plan a disposition that individualizes the child and his situation, and is aimed at correction and rehabilitation. A specialized court is required because of the need for informality, specially qualified judges, probation and clinical facilities to study cases, and (where appropriate) probation supervision and treatment in the community.

A variety of long-term treatment institutions—to provide residential treatment where it would be inappropriate for a court, following adjudication, to return a child to his home or to foster care (for probation or for community-based treatment in a clinic, social agency, or probation department). The residential treatment resources may be: under state or local auspices; public or voluntary; sectarian or nonsectarian; oriented psychiatrically, educationally, or under social work auspices. Disposition authorities in courts, youth authorities, and the like, are seeking to develop criteria for making these choices in the light of a given child's characteristics, background, and potential.

Youth residences, clubs, or hostels—to provide alternate living arrangements after court adjudication in lieu of institutionalization or as part of institutional aftercare for young people whose homes and neighborhoods do not offer suitable environments for rehabilitation. These are "open" facilities; the residents work, go to school, and participate in community activities.

Aftercare services—to provide supervision and treatment in the community for a period after discharge from an institution or residential treatment center. These services may be offered by probation departments, institution staffs, special aftercare staffs, or community agencies.

Planning, coordinating, and evaluation agencies—to assure adequate coverage and cooperation or collaboration as needed, and to determine the effectiveness of the work. Also, as needed, these services should in-

initiate new endeavors. Because of the complexity of the service network each community must make some provision in this realm but its exact form will vary with the place, size of community, and traditions. There is need for both local and state provision. The bodies involved also undertake public education and some prevention tasks.

The above listing deals with specialized resources. Delinquents are also taken care of by many general community resources such as clinics, family agencies, vocational counseling and guidance services, foster care, settlements, and community centers.

How well are United States communities equipped to deal with delinquency?

Not very well. Most juvenile courts are presided over by judges for whom this is a part-time assignment and whose major interests are in adult civil and criminal courts.

Many large cities have no special juvenile aid police; and too few have any or only poorly trained juvenile aid police.

Half the United States counties do not have probation staffs to work with children. Many probation officers are undertrained.

Many training schools are too large and are poorly staffed. Most states do not have smaller residential treatment facilities needed for the more disturbed delinquents.

For lack of juvenile detention facilities many children are detained in jail. The national figure is almost 100,000 a year.

Only a handful of states and large cities have adequate coordination and planning agencies.

How are most reported delinquency cases disposed of?

Most delinquents continue in the community. Most complaints or allegations are ignored, or lead to advice or referral to the clergy, voluntary agencies, or informal sources of help. Many complaints are terminated within police departments.

Of all juvenile court cases, half are informally dealt with in the courts, i.e., there is no official petition and the child's case is not adjudicated. Police and courts sometimes carry out "informal probation" in these cases—a questionable process.

Of all official court delinquency cases, perhaps one-quarter are discharged, close to two-thirds are placed on probation, and the remainder are committed to foster homes or institutions. All these statistics are merely estimates.

What is the task of professionals in the mental health field who work with delinquents?

Again, answers vary somewhat with definitions of terms. Several things do seem clear. First, psychiatric knowledge and psychological knowledge about personality development and psychopathology must enter into the training of teachers, public health nurses, judges, juvenile aid officers, and others involved in early case finding, referral, and exercise of discretion about detention, follow-up, and so on. The purpose of conveying this knowledge is not to make these persons psychotherapists or to change their tasks; it is rather, to heighten sensitivity to serious deviance and to suggest how one's own actions and attitudes may be perceived by those in trouble.

In addition, police bureaus, courts, and schools require adequately trained clinical personnel to carry out comprehensive social and psychiatric studies essential to diagnosis and the planning of treatment services.

Next, probation departments, institutions, residential centers, community clinics, and others require well-qualified personnel to carry out both case evaluations and the treatment services appropriate to the setting or institution. Clinical personnel who expect to work with delinquents will want to give particular attention to the problem of "acting out" children, to the behavior disorders, and character disorders. They will also want to become acquainted with the social and cultural contexts of delinquency as these affect their treatment.

Why is there so much failure in the treatment of delinquents?

The question's built-in premise is correct. Although the exact extent of the failures is unknown, failure rates are high. Many discharged cases come back to the police; and many former probationers appear in training schools. Perhaps 55 to 65 per cent of training school graduates reappear in juvenile court or eventually reach correctional institutions for young offenders or adults. Recidivism, repeated delinquency or crime, is very high.

None of this is surprising although it does emphasize how much is yet to be done. As indicated above, most of the resources defined as essential to dealing with those in trouble are not yet available across the board. Even less often are they all available in one place. Therefore, the community tends to deal with individual cases in inconsistent, sporadic fashion. The police may be adequately staffed; but probation is not. The court may do its job, but may not have access to needed

residential treatment resources. The institution may be well staffed; but there may not be community residential facilities. Failure rates may prove that existing services are ineffective, or that they do not yet generally exist in adequate numbers, in one place, and in a coordinated network.

The results of intensive demonstrations and projects do suggest, however, that the inherent complexity of the task and the limitations of knowledge and skill are also involved in the failures:

- (a) Many delinquents are returned to the families, peer groups, and neighborhoods in which they originally developed their attitudes and problems. Even the work of most effective institutions may be quickly lost by an ever-present, salient environment.
- (b) Effective work may be done with an entire antisocial gang only to collapse when the members, now ready to conform and to take their places in respectable society, are unable to find suitable work and housing, or lack the skills and habits needed for success on the job.
- (c) "Reformed" offenders may discover that the community, the labor market, and authorities generally continue to see them as poor risks.
- (d) Individual and group treatment programs—using all available methods—are simply unable to reach and affect some offenders because of the inherent complexity of the psychological and social problems, and the lack of sufficient knowledge to do the right thing.

Are there any new, promising approaches to control, treatment, and rehabilitation?

Yes, the 1960's are an era of promising developments. While not all students of delinquency agree as to what are the most promising of current developments, the following is a representative listing:

- 1) The tendency to stress family diagnosis and family treatment where once the individual was dealt with as though he resided in a vacuum.
- 2) The increased experimentation with group services and group therapies.
- 3) The "detached" gang workers who meet antisocial groups in their own local areas, establish relationships with them, and seek to guide the members individually or the group as a whole toward more constructive futures.
- 4) The experimentation with intensive community-based treatments

of all sorts as an alternative to costly and often unsuccessful institutionalization.

- 5) The improved staffing of community and institutional programs with clinically oriented staffs and the efforts to determine when psychiatrically oriented therapies are appropriate, and when the approach should be on the level of social functioning, value orientation, or educational programs.
- 6) The new, imaginative vocational guidance, training, and placement programs which "reach out" to underprivileged youth who are not themselves adequately equipped to take the necessary initiative.
- 7) The "reaching out" programs in the social agencies which recognize that economic, cultural, and social deprivations often make it impossible for people who need the service to meet the agency even halfway, at least initially.
- 8) Various local experiments at integration of service at the case level.
- 9) New, energetic statewide and municipal coordinating, planning, and staff-training programs.

Where does federal leadership come from in this field?

The United States Children's Bureau in the Department of Health, Education, and Welfare (H.E.W.) conducts studies and assembles statistical reports. Through its Juvenile Delinquency Services Division it carries out a comprehensive program of field consultation and aid to states and localities. Within the same department, the National Institute of Mental Health grants funds for research and demonstrations in this field. Also in H.E.W., the United States Office of Education is conducting a major program to curtail school dropouts and to improve educational offerings for youths in large cities for whom traditional academic offerings are beyond reach.

The United States Department of Labor takes the lead in relation to job placement, training, and counseling for out-of-school youths.

The Justice Department deals with young federal offenders.

The Juvenile Delinquency and Youth Offenses Act of 1961 created the President's Committee on Juvenile Delinquency and Youth Crime as a coordinating, leadership, and fund-granting body. It consists of the Secretaries of Labor, Justice, and Health, Education, and Welfare, and is responsible for federal programs of demonstration, expanded training opportunity, information, and consultation.

LAW AND PSYCHIATRY

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What is meant by the words insanity, idiocy, and lunacy?

These are ancient words, much used by the law, that have only social and legal meanings and are never used by physicians as medical diagnoses. *Insanity* refers to a condition of unsoundness of mind making one unfit to manage one's own affairs and perform one's social obligations. An insane person may be committed to a hospital for medical treatment against his own wish. A will made by an insane person may be held to be invalid. A contract entered into by an insane person may be voided. An insane person is not held to be responsible for his actions before the law and thus may escape responsibility for actions that would otherwise be considered criminal.

The word *idiot* is derived from a Greek word meaning a private person, that is, one who did not hold public office. Later it came to mean an ignorant person, a fool, or a jester. In the law it means a person who has been so mentally deficient all his life that he cannot be held accountable to the law nor can he be allowed to manage his own affairs.

Lunacy is a very old legal term denoting a cyclical type of insanity in which periods of mental derangement alternate with periods of lucidity. The word is derived from the Latin word *luna*, the moon, for it was believed that the cycles of the moon influenced the cycles of mental illness.

Because these are legal, not medical, terms, they are defined and described by the law, rather than by medicine. Psychiatrists usually have great difficulty fitting their medical concepts and definitions into those required by the law. Traditionally the law does not hesitate to assign different definitions to the same legal word or phrase depending upon the context in which it is used. Insanity is defined one way in determining competency to make a will, a different way in deciding whether a patient should be committed to a hospital for psychiatric treatment, and still another way in determining legal questions of guilt and criminal responsibility. These definitions are known as

"rules" and are sometimes named after the person involved in important legal trials when the particular rule was established.

What is the basic rule of criminal responsibility of the mentally ill?

Mental disease or defect by itself does not excuse a defendant from responsibility for his criminal actions. The law insists that a mentally ill or defective individual have a certain degree of mental sickness or mental deficiency that meets the requirements of the particular rules for legal insanity or idiocy before he can be excused from responsibility. If he does not meet the specifications of the legal rules, he may be imprisoned or even executed even though medically he may be very mentally ill. The most famous rule of criminal responsibility is the M'Naghten Rule. This rule is used in most English-speaking countries and in most of the United States as the sole criterion of criminal responsibility of the mentally ill.

M'Naghten was a young Scotsman who developed the delusion that he was being persecuted by the Tory Party in England. In 1843 he decided that the only remedy for his trouble was to assassinate Sir Robert Peel, the Prime Minister of England. Through a case of mistaken identity he shot and killed Sir Robert Peel's secretary, Edward Drummond, believing that he had actually killed the prime minister. M'Naghten's trial for murder was most sensational, because the public and most government officials, even Queen Victoria, were convinced that the assassination was a political plot against the government and that M'Naghten had been hired by the opposing political party. However, in keeping with the best British tradition, M'Naghten received a scrupulously fair trial.

All medical experts testified that M'Naghten was suffering from delusions and that the assassination was the result of his mental illness. The chief justice directed the jury to bring in a verdict of "not guilty by reason of insanity," and M'Naghten was committed to a mental institution where he remained the rest of his life. Despite the acquittal, the public furor over the assassination did not subside and there was much heated debate over laws that would allow such an assassin to escape punishment. The culmination was a debate in the House of Lords during which the fifteen chief justices of England were asked to reply to five questions submitted to them concerning the manner in which they determined the criminal responsibility or legal insanity in such cases as M'Naghten's. Their reply to one of the questions has become firmly embalmed in the law of all English-speaking countries as the *M'Naghten*

ten Rule. The justices said: "To establish a defense on the ground of insanity, it must be clearly proved, that at the time of committing the act, the party accused was laboring under such a defect of reason from disease of the mind, as not to know the nature and quality of the act he was doing, or if he did know it, that he did not know he was doing what was wrong. The mode of putting the latter part of the question to the jury on these occasions has generally been, whether the accused at the time of doing the act knew the difference between right and wrong. . . ." This is often referred to as the "knowledge of right and wrong" test of criminal responsibility.

Since this rule was formulated in 1843, there has been constant argument and debate between the medical and legal professions as to the justice and propriety of its use as the criteria of legal insanity. Especially many psychiatrists believe it to be unjust. They point out that the rule refers only to derangement of cognition and that most mentally ill persons know perfectly well what they are doing; nevertheless, they cannot help doing what they do, for they suffer from disorders of self-control, motivation, and behavior not within their power to restrain. To the psychiatrist, mental disease shows itself much more by defects of volition than by defects of cognition. Hence, under a strict interpretation of the M'Naghten Rule many defendants who are seriously mentally ill are held to be strictly accountable for their actions and receive the full punishment of the law. .

Many attempts have been made to modify the harshness of the right and wrong test, but only a few have been accepted by the law and then only in restricted jurisdictions. No rule has ever been formulated that has received the wholehearted support of both psychiatry and the law.

What is the "irresistible impulse" rule?

A minority of our states permit a supplementary rule of criminal responsibility that takes into consideration the volitional defects of the defendant. In these states, even though the defendant knows the nature and quality of his act and that what he did was wrong, if it can be proven that the criminal act was the result of an abnormal mental impulse and that the defendant was totally lacking in powers of self-control over the impulse, he is entitled to be acquitted on the grounds of insanity.

Although the "irresistible impulse" rule is less strict than the right and wrong test, it still does not seem to provide a satisfactory solution to

the problem. It is extremely difficult to know with any reasonable degree of certainty whether such an impulse exists in the mind of a particular defendant, and even more difficult to prove that the impulse could not have been restrained under all circumstances. The courts have tended to insist upon a very narrow interpretation of this rule by demanding to know from the psychiatric expert whether the defendant would have committed the same crime if a policeman had been standing at the defendant's elbow at the time of the crime. This has become known as the "policeman at the elbow" test.

What is the Durham Rule?

In 1954, the United States Court of Appeals for the District of Columbia handed down a decision completely revising the traditional doctrines of criminal insanity. In this *Durham* decision, Judge David L. Bazelon wrote that the M'Naghten formula must be replaced by a new rule which "is simply that an accused is not criminally responsible if his unlawful act was the product of mental disease or defect." The *Durham* decision is a great modern landmark in legal psychiatry and has aroused much controversy. It has especially stimulated intense interest by both the legal and medical professions with a subsequent renewal of efforts in other parts of the country to achieve a more satisfactory means of coping with the problem of mental illness and crime.

From its inception, the *Durham* decision was hailed by psychiatrists as an enlightened advance in the humane treatment of the mentally ill. Many had high hopes that this rule might be adopted by most of the other states and that at last the law would give proper recognition to the role that mental illness plays in the causation of crime. The *Durham* Rule has been adopted by the Virgin Islands and, in a somewhat restricted form, by the state of Maine. But there has been strong opposition by conservative legal groups throughout the country and it has been rejected by all other state courts. There appears to be little likelihood that the *Durham* Rule will spread to many other jurisdictions.

Legal criticisms of the *Durham* Rule express fear that under such a formula far too many criminals will be adjudged insane and sent to hospitals or set free, when they should be punished and sent to prison. It has been correctly pointed out that there is no generally accepted definition by psychiatrists of just what is included under the rubric "mental disease," and even if the psychiatrists are agreed that a defendant is suffering from a mental disease, how can the psychiatrists or

the courts determine whether the criminal act was truly a product of that disease?

Particular difficulty arises in the classification of those individuals who suffer only from a disorder of personality or character. Psychiatry has long acknowledged that there are many persons who are not suffering from a major mental illness such as a psychosis or even from a minor mental or emotional disease such as a psychoneurosis, but who possess defects or abnormalities of character development that prevent them from achieving a normal relationship to society. Such persons have been variously designated as psychopaths, psychopathic personalities, sociopathic personalities, and by a variety of other terms implying an intrinsic disturbance of personality and social adjustment. Should such cases be excused from criminal responsibility?

For the first two years the Durham Rule was in effect in the District of Columbia, the psychiatric experts generally testified that defendants with personality disorders were not mentally diseased and hence were not legally insane even under the liberal Durham formula. However, since 1956, District of Columbia psychiatrists have tended to include the personality disorders as mental diseases. As a result there has been a tenfold increase in the number of acquittals by reason of insanity in the District of Columbia. This has not meant that the defendants were set free. In the District of Columbia, commitment to a mental hospital is mandatory for anyone acquitted on the grounds of insanity. Paradoxically there has been a recent trend toward the urging of an insanity verdict by the prosecution attorneys in cases of relatively minor offenses, so that such persons may be committed for long periods of time to the detention wards of St. Elizabeths Hospital, where otherwise they would have been convicted and would have received short jail sentences.

Even if the Durham Rule will eventually be abandoned by all jurisdictions, this decision by Judge Bazelon will still be one of the great decisions in the history of criminal law because of the powerful impetus it has given to the search for an answer to the age-old question of moral responsibility.

What is the most recent rule of criminal responsibility of the mentally ill?

The latest rule of criminal responsibility of the mentally ill was handed down (on May 1, 1961) in a decision in the case of Donald Kenneth Currens, an automobile thief, by the United States Court of Appeals for the Third Circuit (Pennsylvania, New Jersey, Delaware, and

the Virgin Islands). The court, in a scholarly decision written by Chief Judge John Biggs, Jr., a distinguished authority in the field of psychiatry and the law, decided that: "The jury must be satisfied that at the time of committing the prohibited act the defendant, as a result of mental disease or defect, lacked substantial capacity to conform his conduct to the requirements of the law which he is alleged to have violated."

In effect the *Currens* Rule says that if a person accused of crime was mentally ill or mentally defective and because of this could not help doing what he did, he shall not be convicted as a criminal. This simple concept of criminal responsibility may well turn out to be the long sought answer; but it is far too soon to evaluate the operation of this new rule. Certainly to the psychiatrist it is as liberal and humane as the Durham Rule is. Whether it will be acceptable to conservative judges and lawyers remains to be seen.

What is moral insanity?

For over a hundred years there have been sporadic attempts by a few physicians to persuade the law to recognize the existence of an intrinsic moral defect in certain individuals who are not otherwise obviously mentally ill. It has been asserted that such moral defectives are not deliberately criminal or evil in intention, but that they lack a sense of moral judgment analogous to the lack of intellectual judgment of the feeble-minded. Such morally deficient defendants should be acquitted, it was argued, as morally insane, in the same way that a mentally ill defendant would be acquitted for insanity.

These arguments have subsided in that it is now recognized that such moral deficiencies are only part of a total personality disorder. Yet if the personality and character disorders, such as psychopathic personality, are recognized as mental diseases as they are under the Durham and Currens rules, then in effect society has given recognition to a kind of moral insanity, and acknowledges through their exculpation from criminal guilt that such deficient individuals are entitled to special consideration as are the more frankly mentally sick. Whether this is considered to be a good or a bad principle depends largely upon one's point of view about crime, punishment, morality, and human nature, and cannot be determined by scientific or wholly logical reasoning.

What is meant by "partial insanity"?

"Partial insanity" is an archaic relic of the days when it was believed that the human mind could be divided into compartments and

that the mental faculties within each compartment of the mind were independent of the others. It was thought that certain mental diseases might affect one mental faculty without influencing other faculties. Thus, a person might have insane delusions about certain things, but be wholly normal in all other respects.

Modern theories of psychology and psychiatry view the human being as a totality, an indivisible entity. Anything that affects one part or function of the individual must necessarily affect the entire individual. Therefore there can be no partial insanity or monomania. In the past, courts have made considerable efforts to define just when a case of partial insanity was or was not criminally responsible. Such decisions have no present-day importance. This represents one of the few instances where medicine and the law have reached a complete accord.

What is meant by partial or diminished responsibility?

The criminal law is pretty much an all-or-none matter. A defendant is either guilty or innocent, sane or insane. But human nature is seldom all-or-none. People are not all good or all bad. The law assumes that, unless proven otherwise, a criminal act is the result of a willful, conscious choice by the defendant—that he deliberately intended to do evil and that he might have chosen to do good if he had exercised a proper sense of moral judgment. The law administers punishment for misdeeds in order to deter the particular criminal from offending again, and it is hoped that by setting an example it will also deter others from doing wrong. In addition, punishment of the offender seems to fulfill a deep psychological need of the public to retaliate against the criminal and “even the score.”

Everything that we know about depth psychology teaches us that human beings are never in full conscious control of themselves. Even the most trivial daily behavior is partially motivated and determined by unconscious mental and emotional forces of which the individual is unaware. What we think is a deliberate, willful choice in our own conduct may turn out to be quite different if our minds are probed for the real forces that decide our behavior. This is especially so with individuals who are suffering from emotional disorders. Even though such a person may appear to be quite normal or to be suffering from a mild mental illness falling far short of that required to establish legal insanity, he may still be impelled toward criminal deeds over which he has little power of conscious decision.

There is reason to believe that only a small minority of criminal

offenders are suffering from a major mental disease that would make them completely unaccountable for their actions. Yet probably only an equally small minority commit crimes from willful choice and should be held fully accountable. The majority of offenders fall somewhere in between these two extremes. This is particularly true of crimes of passion and violence.

Until recently the law has resisted making any provisions for an intermediate type of responsibility for those offenders who were not insane, but who at the same time are not wholly normal in their mental and emotional reactions. As a consequence our prisons are filled with large numbers of mentally disturbed persons who are receiving severe punishment for actions that were not fully under their power of control, and little if anything is being done to treat the underlying mental and emotional problems. It is not surprising that such offenders learn nothing from their punishment and quickly get into trouble again following their release.

"Partial or diminished responsibility" is a way of coping with this problem. Offenders with varying degrees of mental disorder are not thereby excused from responsibility, but are held accountable for an offense of lesser degree than the objective elements of the crime would ordinarily justify. Thus with a crime that usually would result in a first degree murder conviction, the defendant may be able to prove that because of mental illness he was not capable of having the criminal intent required for the definition of first degree murder, and hence can only be convicted of second degree murder or of manslaughter.

The graduated scale of responsibility inherent in the traditional legal gradations of homicide provide a convenient framework upon which this principle of diminished responsibility of the mentally ill can be engrafted. Psychiatric evidence thereby becomes very pertinent to the determination of criminal intent, premeditation, malice, purpose, and design which are elements of the crime being considered by the jury to establish guilt for a particular offense. Eleven states now accept this type of psychiatric evidence. A similar doctrine was adopted in England in 1957, whereby murder is reduced to manslaughter if there is substantial evidence of mental disease short of insanity.

A necessary corollary of diminished responsibility is the establishment of adequate psychiatric treatment facilities within the prison system. Experience with progressive correctional systems, such as in California, in the federal prisons, and in some European countries has amply demonstrated that good psychiatric treatment can be provided

within a prison, and that results are comparable to those achieved in mental hospitals. This can only be done, however, if the prison system is free from brutality and inhumane restrictions, and the correctional staff and administrative leaders are genuinely interested in rehabilitation rather than in punishment.

A small group of psychiatrists and lawyers believe that diminished responsibility may ultimately provide a better solution for the problem of the offender of abnormal character development than by including him among the insane, as is done under the Durham and Currens rules. They believe that this principle would prove to be especially effective if it were coupled with extensive use of the indeterminate sentence so that eventual release of the offender would depend upon his response to rehabilitation and treatment rather than upon the nature of his criminal deed.

Do psychiatrists believe that all criminals are sick?

No, psychiatrists definitely do not believe that all criminals are sick or that crime is a disease. In any large prison one will find every type of person, rich and poor, educated and ignorant, strong and weak, mentally ill and mentally sound. Prison inmates are of all races, creeds, and color, and no one category of person is a criminal type, nor is any category of person always an upright, moral citizen.

Nevertheless, crime is a form of social deviation. It is a fundamental principle of human psychology that one form of deviation tends to be linked to other forms. This is true, even though there may not be a causal relationship between the various deviations. So it is to be expected that criminal offenders would have a much higher rate of mental disease and defect than would the public at large. Similarly, one would expect a substantial number of prisoners to come from social backgrounds of poverty, ignorance, broken homes, and emotional disorder. Furthermore, we know that the prison population is not necessarily representative of the entire population of criminal offenders. Prisoners include only those offenders whose crimes have been detected and who have been convicted. Perhaps the offenders who are more "normal," more psychologically and socially capable, stand a better chance of escaping punishment, leaving the prisons to accumulate the obviously deviant in larger numbers.

Among known offenders, mental illness varies greatly according to the type of offense. Certain crimes, such as child molesting, rarely if ever, are committed by mature, mentally healthy persons of normal

socioeconomic background. On the other hand, income tax violations could well be committed by much more normal individuals. In general, crimes of violence, great passion, senseless brutality, sexual offenses, and crimes against children are likely to be correlated with pronounced mental abnormalities in just about every case.

Do psychiatrists advocate that prisons should be turned into hospitals?

No, psychiatrists generally do not believe that prisons should be transformed into hospitals. Prisons are constantly confronted with problems of security and protection of society that do not often arise in hospitals. In many ways the goals and methods of the prison cannot be identical with those of the hospitals. Yet psychiatrists do believe that certain aspects of medical practice and tradition could be usefully applied to the correctional system. They particularly advocate the application of scientific methods of evaluation of the individual and his problems and the development of humane, individually prescribed treatment and rehabilitation programs administered by staffs of highly trained, well-paid professionals of all disciplines of the behavioral sciences. Modern hospitals are places of research and all the techniques of modern science are available in an ever-progressive program of investigation, experimentation, and evaluation. Compare this with the paucity of research in our prisons and the lack of even a pretense of rehabilitation in many of our largest prisons. The rigidity of the criminal law and the correctional system often thwart any efforts at experimentation or learning from trial and error. It is no wonder that so little progress has been made in the discovery of the cause and cure of crime.

Are psychiatrists frequently used by the law courts in civil cases?

Although the psychiatric expert receives most public attention when he testifies in sensational criminal trials, psychiatry is actually used much more frequently in civil procedures. Psychiatric evidence is utilized in civil commitment procedures for hospitalization of the mentally ill, for guardianship actions, will contests, divorce and child custody cases, personal injury suits, workmen's compensation hearings, and many other judicial and quasi-judicial procedures. The use of such psychiatric evidence is rapidly increasing. It seems probable that it will be in these noncriminal legal proceedings that psychiatry will perform its major function for the law in the future.

Is not the "battle of the experts" a reflection on the integrity and knowledge of the psychiatrist?

Our traditional Anglo-American legal system relies heavily upon the adversary principle. Our democratic society believes that in the long run justice is more nearly approached through a system in which each side advocates its side through evidence, argument, and persuasion. As a necessary part of this adversary process, each side must call its own witnesses—both laymen and experts—who support their point of view. The experts frequently disagree, giving the public the impression that they are either dishonest or that they do not know what they are talking about. This is not true.

Legal trials by their very nature involve controversial matters. Seldom are the issues clear-cut with the weight of evidence overwhelming on one side or the other. If they were, there would be no dispute and no necessity for a trial. The expert witness gives as evidence his professional opinion and the basis upon which he formed his opinion. Because the basic issues of the trial are controversial and the facts are seldom precisely one way or the other, the experts will frequently disagree. Further, different experts represent various schools of thought and express different points of view.

In certain specialized areas of the law, so-called impartial boards of experts have been used. But it would be a mistake to assume that our entire adversary system should be replaced with such boards. Expert judgment is never infallible, and only too often within such a board of experts there is wide difference of opinion. The report of the board of experts may not include these differing conclusions, giving itself a spurious appearance of certainty and unanimity. The judge and jury trying a case are entitled to consider all the pertinent evidence and opinions, not just the fraction that has been filtered through a group of experts.

Every person has a strong need for certainty. The necessity for responsibility in the face of doubt and uncertainty stimulates anxiety in all of us. We would like to believe that in all matters there exists an absolute truth that could be determined if we only had the proper information. Unfortunately, few things can be known with certainty, therefore experts as well as lay persons will always disagree. This is just as true for scientific experts as for medical experts. In a recent hearing to determine whether it would be safe to reconstruct the famed Golden Gate Bridge so that it might carry trains as well as autos, a distinguished bridge engineer testified that it would be perfectly feasible

and safe to do so. An equally experienced engineer was adamant in his belief that it would not be safe to alter the bridge. A human being is infinitely more complex than a bridge. Hence in human affairs there must always be uncertainty. We should be proud that we have been able to develop a system of law that provides the means of making vital social decisions in the face of controversy and uncertainty and still—in the long run and in most cases—is fair and just.

What part does psychiatry play in civil law? Personal injuries? Wills? Contracts and deeds? Annulment and divorce? Guardianship?

There are a large number of legal issues where the mental or emotional state of the parties concerned is brought into question. In each of these issues the law calls upon the psychiatrist for expert guidance, and the psychiatrist may be called as an expert witness for either side of the controversy.

In a suit for damages for personal injury, the plaintiff may contend that he was injured in some sort of psychological way in addition to, or instead of, a physical injury. Automobile and industrial accidents may lead to crippling mental and emotional disabilities aside from the physical injuries received. Such psychological injuries are compensable according to the degree of psychological injury received and the permanence and extent of the resultant disability. A recent decision has held that a patient who developed a morbid fear of cancer following an otherwise insignificant X-ray burn was entitled to damages.

Compensation for psychological or emotional injury presents many problems for the law and for the psychiatric expert. It is known that the knowledge that compensation or damages can be secured may, in itself, encourage psychological disability, and it is very difficult to segregate those incapacities that are directly the result of the original injury and those that are a consequence of the legal action itself. In some cases being "paid" for being sick tends to perpetuate the psychological disability. Such cases are loosely called "compensation neuroses." In other cases the receipt of a monetary reward or recompense is an important element in the recovery of the patient.

To make the situation even more complicated, psychiatry today believes that physical trauma or psychological shock to a well-adjusted adult only rarely, if ever, can produce a permanent psychological or emotional disability. Individuals who tend to become disabled following adult experiences almost invariably give evidence of preexisting neurotic traits, emotional instability, and maladjustment. The accident

or injury for which damages are sought is then less a true causal agent than it is a triggering or aggravating factor. Most states permit recovery of damages even though there has been substantial predisposition toward psychological disability.

Wills present special psychological problems for the law. For a will to be valid the maker of the will must be of sound mind at the time the will is executed. By this the law means that the person must have sufficient mental capacity to understand the extent and nature of his property as well as his relationship and obligations to his potential heirs. Since many wills are made by persons in times of serious illness or at an advanced age, the question often arises as to whether a deceased person really knew what he was doing when he decided upon the disposition of his estate. Also there may arise the issue of undue influence. If it can be demonstrated that some person who stands to benefit by the will exerted undue psychological pressure upon the maker of the will, then the will may be declared invalid. Physically or mentally ill people and particularly senile, aged persons are very susceptible to suggestion and emotional pressure. It is not difficult for a friend or relative to convince such a sick individual to change his will at the last moment and divide his estate in ways the person would never have thought of doing had he had normal powers of reasoning at the time.

The psychiatric expert witness is in a particularly difficult position in giving evidence in these cases. He is almost invariably called into the case after the individual concerned is dead and is asked to give an opinion about the mental state of a person whom he has never personally examined. He must rely on indirect evidence of whatever type is available and it should be no surprise if differences of opinions exist between the experts.

Since ancient Roman law, for a contract or deed to be legally valid, the parties concerned must be of sufficiently sound mind properly to understand the nature of the transaction and the obligations that have been incurred. The law has always zealously protected the property rights of those members of society who, because of mental disease or mental deficiency, cannot look after their own rights. If an individual is found to be mentally incapable of handling his own affairs, the law may appoint a guardian who has the obligation to do this for the mentally ill or retarded person.

It is most important to bear in mind that a legal adjudication of incompetency or irresponsibility for one particular legal purpose does

not establish a disability in other legal issues. Thus a patient may be adjudged "insane" for purposes of commitment to a mental hospital for psychiatric treatment, and at the same time may be found to be quite "sane" for the purposes of making a will or disposing of his property, or he may be tried and convicted for a criminal offense, with full responsibility for his deeds. For each legal issue different criteria of mental responsibility may be used. Although evidence of incompetency in one legal situation may be used as evidence of incompetency in another, such evidence is not at all conclusive. Further, the various standards or criteria used by the law in deciding all these issues vary from jurisdiction to jurisdiction. An experienced, competent lawyer, familiar with the latest judicial decisions, is needed to advise in each individual case.

How is an individual found to be mentally fit for trial?

It is a fundamental constitutional right of all persons in this country to have a fair trial, to be entitled to "due process" of law. Just what "due process" consists of is a matter for determination by the courts and there have been many historic decisions that have laid down the principles involved. One of these is that a defendant in a criminal trial must be of sufficiently normal mental state so as to appreciate the nature of the charges against him, to understand what is happening during the trial, and to be able to cooperate with his defense counsel. If, by reason of mental disease or defect, a defendant is not able to do this, he is considered by the law to be "presently insane" and he cannot be tried at that time.

The question as to whether a defendant is too mentally ill to be tried is most likely to be raised by the defense, but it can be raised by either the prosecution or the trial court. In most states, the court will then appoint psychiatrists to examine the defendant and some type of hearing or trial of this issue, separate from the issue of guilt for the criminal offense, is held. If found sane, the criminal trial may proceed. If found presently insane, no further criminal procedures can take place. He is then ordinarily committed to a mental hospital for care and treatment until such a time as he recovers sufficiently to permit his being tried.

The adjudication of present insanity in no way disposes of the original criminal charges and no matter how many years elapse before recovery ensues, he may still be required to stand trial on the criminal issue. As a matter of practical expediency, if recovery requires a very long time, the criminal charges may be dismissed by the court as soon

as it becomes evident that recovery will be delayed. However, it is not unusual to find old patients in mental hospitals who have been committed twenty-five or more years ago for "present insanity" and who still have hanging over their heads unresolved criminal charges.

A similar situation exists in the execution of the death penalty. Even though an offender may have been legally sane at the time of the trial and at the time of the commission of the criminal act, he may subsequently develop sufficient mental abnormality to prevent his execution. There have been few judicial decisions establishing the criteria for present insanity at the time of execution. In general, however, the rule is that the doomed criminal must comprehend that he is being executed and must know what he has done to deserve that fate. If he is too mentally ill to be executed, the execution must be postponed until such a time as he recovers sufficiently to permit the law to exact its penalty. Society is then confronted with the absurd spectacle of hospitalizing a condemned prisoner, exerting all possible medical skills to restore the prisoner to a semblance of mental health, then returning him to the prison for execution. This is one of those legal anomalies that can be solved only by the complete abolition of capital punishment.

How is the credibility of expert witnesses determined?

It is the obligation of the jury, or of the judge in the absence of the jury, to weigh not only the evidence, but to give full consideration to the credibility of the witnesses who give the evidence. The expert witness gives evidence not as to the facts of the case, but rather as to his "opinion" about certain matters that are relevant to the issues to be decided by the trial. The value of such expert opinion is necessarily dependent upon the credibility of the particular expert. One expert may be very experienced and knowledgeable about the issues at trial; another expert, even though competent in his own professional work, may have little knowledge or experience about the special problems the law must decide.

Thus, at the start of the interrogation of the expert witness, the attorney will ask many questions as to the expert's education, training, professional experience, membership in professional organizations, honors, and the like, all aimed at eliciting information concerning the expert's qualifications as someone to be believed and whose opinions should be given much weight. The attorney on the other side has the right in cross-examination to challenge the qualifications, knowledge, experience, and credibility of the witness.

Not everyone can be put upon a witness stand as an expert and be asked his opinion. There are certain general requirements, such as professional education, licensure, etc., that are required before the witness can even give his opinion. But in addition the expert must establish his special competency and experience in the special issues of the trial at hand. There was a time when merely the possession of a medical degree and license were considered by the law as sufficient basis for giving expert testimony. Recent decisions have tended to insist that the witness be truly an expert in his possession of special skills, knowledge, and experience relevant to the legal issues being tried. Even if the expert witness has established his qualifications in these areas, he can still be challenged by penetrating questions as to how thorough his knowledge is of the particular case at trial. He may be asked how much time he devoted to the study of the case and he may be confronted with information or facts he failed to take into consideration in forming his opinion. He may be asked about contradictory opinions he gave in other cases. Although he may not be unfairly attacked by irrelevant questions, attorneys on either side may ask any type of question that tends to prove or disprove his credibility as an expert who has special knowledge of the case at trial. The jury or judge, as trier of fact, must then carefully weigh the value and credibility of the evidence of all the witnesses, both laymen and experts, and reach a decision.

Why might a psychiatrist be hesitant about giving opinion at a trial?

Psychiatrists, like all physicians, are used to functioning in a relatively authoritarian setting. They are accustomed to having their professional judgment accepted without question or challenge. Whatever doubts or misgivings a patient may feel toward his doctor, he does not usually express them to the doctor's face. There is no doubt that certain authoritarian features of medical practice are detrimental to both the patient and the doctor. But it must be remembered that a physician is called upon to make decisions of vital consequence, at times of great crisis when the individual most concerned—the patient—is totally unable to accept responsibility. It would not be helpful to a patient dying of pneumonia to be asked by his doctor whether he prefers an antibiotic or another medication. As a consequence, thousands of years of historical tradition have developed a system of medical practice in which the authority of the physician is accepted by all without question.

The doctor on the witness stand is confronted with a challenge to his authority for which he is unprepared by training or by tem-

perament. He does not always handle himself well in such an unfamiliar situation. He may respond by great insecurity and give evidence that appears to be weak and faltering even though it is based on sound judgment and knowledge. Or he may react by becoming excessively authoritarian and dogmatic, thus covering up the deficiencies in his own knowledge. In either instance, he is not likely to have enjoyed the experience or felt his prestige to have been enhanced.

In addition, many physicians, including psychiatrists, feel that the questions they are called upon to answer in the courtroom are framed in such a way and presented in such a context that they cannot properly answer them. Certain questions regarded as very basic by the law (for example: Did the defendant have a knowledge of the wrongfulness of his act?) are not matters about which many psychiatrists would feel they have any particular expert knowledge. Further, some psychiatrists would consider such questions as too abstract, too philosophical, and divorced from real human issues, to be able to give a sincere and meaningful answer. Questions, which to the lay person may seem simple indeed, may to the expert with his greater wealth of knowledge and semantic possibilities, appear very complex and unanswerable.

As a consequence of all this, many psychiatrists are exceedingly reluctant to participate in any way in the legal process. Many of the very best clinicians, teachers, and research physicians will not go near a courtroom. In some instances this leaves the medicolegal field open to doctors who are less skilled and sometimes less scrupulous about their professional judgments. Both the special requirements of the law in regard to medical testimony and this hesitancy of many outstanding doctors to engage in legal work often result in an unfortunate discrepancy between standards of medical practice in the courtroom and in the hospital. This is particularly true with psychiatry and is doubly unfortunate in that the only acquaintance large segments of the population have with psychiatry is by way of the public arena of the courtroom in sensational trials. Successfully to resolve this problem will require many compromises by both the professions of law and of medicine—compromises each is reluctant to make. Hence rapport between the two professions is uncertain and slow to progress.

Why might the psychiatric opinion at a trial be looked at with reservation by lawyers, judges, and the public?

The chief reasons why lawyers, judges, and the public are suspicious of psychiatric expert testimony are two: one, psychiatrists often

give their testimony in technical language and express themselves in concepts quite foreign to the thinking of nonpsychiatrists. Such testimony is either not understood at all, or is so badly misunderstood, that the psychiatrist never does get his message across. Further, many, if not most, people are not at all prepared to accept some of the basic theoretical concepts upon which psychiatry is based. Despite the overwhelming scientific evidence of the existence of the unconscious as a motivating and controlling force in human conduct, many people simply do not believe such things. They tend to conceptualize human behavior in overly simple, moralistic, commonsense principles which often appear strongly discrepant to the evidence of the psychiatrists. The psychiatrist's use of technical jargon does not help in reducing this gulf between the psychiatrist and the lawyer. An exceptionally skilled and experienced psychiatrist may still be able to get across to the lay jury his ideas, but a great many otherwise fully competent experts have difficulty with this.

The second reason for distrust of the psychiatric expert is the frequency with which diametrically opposed testimony is offered by the experts of each side. This distrust is not deserved. Legal trials always involve controversy by their very nature. If the issues are clear-cut, easily formulated, and clearly decided, there is no need for a trial. The trial could then be avoided by a compromise settlement out of court, by a plea of guilty, or by dismissal of the charges. By and large, those cases which do come to trial are the most controversial involving borderline issues of considerable complexity. The testimony of the different experts reflects this.

A further factor in causing such confusion and suspicion of the expert is the fact that different psychiatrists, like all experts, fall into different schools of thought about the types of cases with which the law is concerned. Some psychiatrists believe very firmly in the existence of posttraumatic neuroses, for example. Other psychiatrists might believe that all this is nonsense, that a patient who complains of nervousness after an accident is "just putting on an act." Such attitudes lead to consistent biases in testimony. The attorneys for both sides of a legal case know about this and they cannot be blamed for attempting to select the experts who, they believe, are most likely to come up with conclusions favorable to their side.

In ordinary medical practice when strong individual differences of opinion are held by varying groups of doctors, the average practitioner is usually guided by the opinions and practices of the leaders of his

profession, the distinguished teachers of medicine at the great medical centers, and the outstanding practitioners in the community. It is much to be regretted that the medical schools and the outstanding physicians of the community so often have little knowledge or interest in the medicolegal field. Hence their guidance is not available.

What is the Briggs Law?

The *Briggs Law*, named after L. Vernon Briggs, a pioneer in Massachusetts psychiatry, was adopted by Massachusetts in 1921 (and amended in a number of subsequent years) as an attempt to solve the problem of the "battle of the experts" in criminal trials. This law requires a mental examination for certain categories of criminal offenders (all capital cases, and all persons who previously have been indicted for a felony). The examination is to be done by so-called neutral, impartial experts, selected by an independent government agency, e.g., the Department of Mental Diseases of the Commonwealth of Massachusetts.

There is no doubt that the Briggs Law has largely eliminated the battle of experts in Massachusetts. Although the defense or the prosecution has the right to call in its own experts, the official status of the Briggs Law experts carries so much weight that it is usually considered fruitless to dispute their opinion. Nevertheless, many psychiatrists, judges, and lawyers have very grave doubts as to the quality of justice administered under the Briggs Law. A quick and easy decision is reached, to be sure, as to the mental competency of the accused; but whether that is necessarily the right and just decision is another matter. There is reason to believe that the examinations performed under this law are often superficial, inadequate, and grossly biased in favor of the prosecution. The psychiatrists who seek out and receive appointment to the examining boards are, in some instances, punitive and unperceptive in their approach toward the defendant, and they may not always be familiar with the best modern practice and theories of criminal psychopathology.

When first adopted in 1921, the Briggs Law offered considerable promise of being a solution to a very pressing medicolegal problem. In the opinion of this writer, this promise has not been fulfilled.

Must all individuals convicted of a felony be given a mental examination?

There is no state or jurisdiction in the United States which requires, by law, that all individuals convicted of a felony be given a

mental examination. Actual practice varies widely, both as to the number of such convicted felons who receive psychiatric attention and the depth and scope of such examinations. Some courts, such as those in Baltimore, have available a psychiatric clinic that has been organized specifically for the purpose of providing guidance to the law in the handling of psychiatric problems. In such courts referral to the psychiatrist is made very frequently, not only for opinion as to the legal issues involved, but in determining questions of disposition, probation prospects, rehabilitation requirements, etc. In the California Department of Corrections and in the Federal Bureau of Prisons extensive psychiatric facilities are available for diagnosis and treatment. But even in these advanced institutions the great number of prisoners who are convicted of felonies preclude routine examinations.

It would be fair to say that today in most jurisdictions of the United States, unless a defendant is so grossly mentally ill that casual observation by a nonpsychiatrist can detect the disease, or unless the defendant has a very alert defense attorney who insists upon examination by a competent expert, a criminal offender, of either a felony or misdemeanor, stands little chance of having his mental illness recognized and treated, before or after conviction.

Thus, one does not know with any degree of reliability what percentage of our criminal offenders actually are mentally ill. Those cases that come to the attention of the courts or prisons may not at all represent an accurate index of the prevalency of mental disease and abnormality among the total criminal population.

By and large, society has barely scratched the surface as to the possibilities of the use of psychiatry and the behavioral sciences in the understanding, care, and treatment of the criminal offender. It is not always easy, at the present time, to know precisely how much of the vast body of scientific knowledge accumulated by the social, behavioral, and medical sciences could be directly applied to the problems of penology and administration of criminal justice. Much would have to be learned by trial and error, and further research on the overall problem of social and psychological deviancy is required. But unless direct attempts to apply such knowledge are made, progress will be hampered.

What steps could bring improvement in the workings of law and psychiatry?

Many concrete suggestions could be given as to possible reforms in the mutual operations of psychiatry and the law. None of these sug-

gestions would receive unanimous endorsement by both the entire legal profession or the entire psychiatric profession. Reforms are never unanimously endorsed by any group. Further, many of the more significant reforms would require extensive readjustment of public attitudes toward crime and the criminal offender.

The most obvious step that would ensure better working relations between psychiatry and the law would be the adoption of a more liberal and realistic rule of criminal responsibility, such as that laid down in the *Currens* decision. The expansion of the concept of diminished or limited responsibility would also help to break down the rigidity of the law's all-or-none attitudes. But such reforms must also be accompanied by the establishment of adequate psychiatric treatment programs within the correctional system. And for those defendants who are to be sent to mental hospitals instead of to prisons, adequate safeguards must be devised to ensure that they are not released before the danger to society has passed.

There is an urgent need for the development of a system of presentation of expert evidence to the trial court in some other way than the clumsy interrogation system. Here there must be compromises on the part of both psychiatry and the law. The doctor cannot insist on the right to be listened to without question or challenge; but at the same time the law must recognize that the communication of professional, technical information requires special methods that may not be provided by the ordinary rules of evidence. Medicolegal work must be made thoroughly respectable and highly ethical, which it is not now. But if the best medical talents are to be attracted to the field, this must be accomplished.

Lawyers must be taught more about psychiatry and human behavior. Such teaching, if done in the courtroom, is far too late. It should be done in the law schools where some aspects of the law should be taught as a special type of applied behavioral science. Similarly, physicians must become acquainted with basic legal principles and philosophy early in their medical career.

Of much greater importance than any particular reform or improvement in the workings of law and psychiatry would be for the entire public, not just lawyers and psychiatrists, to face certain basic failures in the present system of administration of criminal justice. These failures could all be lumped together under a single criticism: the system does not do what it is supposed to do. Our courts of criminal justice and our prisons are supposed to rehabilitate the individual offender

or at least prevent him from preying upon society. Our system of criminal justice is supposed to protect society against crime. This it does not do. Nor is there evidence that any significant progress, through the conventional means of moral condemnation, punishment, and vengeful retribution, has been made in hundreds and hundreds of years of experience with the system.

There is no particular reason to believe that psychiatry, or any other of the behavioral sciences, has the answer either. But they, like all the sciences, do have a method, an approach, that promises much. This is the scientific method of description, categorizing, hypothesizing, and finally putting the hypotheses to test through trial and error experimentation. Results are closely and objectively analyzed and modifications in the theories and practices are made in accordance with the results.

In the thousands of years that the law has been punishing criminals it seems to have learned little or nothing about what makes a criminal do what he does. And the law has learned little or nothing as to how it can make the criminal stop doing what he does. This is in sharp contrast to the medical and the natural sciences where new discoveries have brought untold benefits (as well as liabilities) to the modern world. Someday, let us hope soon, the law must learn to apply the scientific method, be it in the guise of psychiatry, sociology, psychology, or penology to that most pressing of all social ills—crime.

LEARNING AND READING

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What is learning?

Although the average person thinks of learning in school—learning to read, learning arithmetic, learning American history—when scientists think of “learning,” they understand the term more broadly. “Learning” is the process by which behavior is changed through training (rather than by fatigue, or growth, or other factors not considered to be “training”). One learns to read, to add, to spell, and to tell in what year Columbus discovered America; one also learns to drive a car, to like asparagus, and to enjoy listening to a Beethoven string quartet. Some learning is deliberate or takes place because planned instruction is given, but other learning occurs without intention by the learner and without plan by someone else.

How does learning take place?

Learning occurs when four necessary conditions for learning exist: motivation, cue, response, and reward. To put it in everyday language, if a person is to learn he must *want* something, *see* something, *do* something, and *get* something. For example, the student learning to play a flute must want to play the flute or at least want the praise of the teacher when he plays the right note with an acceptable intonation (motivation); he must see the written note in the music he is learning to play (cue); he must play the correct note (response); and he must get a reward for doing so. The reward, in this example, may be the knowledge that he has played the right note—knowledge that is rewarding because the student wants to learn the flute; or it may be praise by the teacher; or it may be absence of criticism by the teacher, since escape from criticism is rewarding.

What are the various theories of learning?

First let it be said that "learning theory" means the scientific explanation of how learning takes place. When we pointed out that learning requires four factors—motivation, cue, response, and reward—we were drawing upon a learning theory. Every science has its unanswered questions, of course, and learning theory has its problems. For example, are all rewards (or "reinforcements," as they are called technically) brought about by satisfaction of a drive? Or can reinforcements occur whenever a person perceives a connection between two events? On one side of this controversy stand those who hold to a stimulus-response, drive-reduction theory; on the other, those who hold to a cognitive, perceptual, or "Gestalt" theory. Despite theoretical controversies there is a good deal of agreement at the level of practical applications.

Is everyone able to learn?

The ability to learn obviously depends on the ability to perceive cues and on the ability to make the required response. A color-blind man cannot learn to communicate with colored Navy signal flags; a person whose fingers are paralyzed cannot learn to play the piano. Motivation and reward are essential, too; a child of the slums, if he has never learned to want to please adults and if he has practically no chance of becoming a professional person because of social and economic barriers, cannot be expected to have the motivation to learn English literature and algebra, nor can he be expected to find rewards in doing so. He can be expected to want to learn how to defend himself against attack by members of rival gangs, and to find it rewarding when he hits upon a way of protecting himself. Therefore he will not learn English or algebra, but he will learn to fight effectively.

What influences the desire to learn?

We see from the answer to the preceding question that "desire to learn" depends upon all the relevant previous experiences a person has had. The slum child of the previous example wanted to learn to fight, but did not want to learn English or algebra. If the question is asked more specifically, "What influences a desire to learn school subjects?" we can answer that two factors are quite important. First, a child wants to learn in school if he has learned to want to please his parents and other adults. Second, a child wants to learn in school if he can

anticipate that he will find the knowledge and skills that he learns useful in his everyday life. To illustrate: A child who for some reason is sullen and rebellious toward his parents most likely will not do well in his schoolwork. A child who does not anticipate that mastery of school subjects will be useful in his life is unlikely to learn school subjects well. If, for example, the child's parents do not read books or magazines, if his father's work does not require literacy, and if the parents are not interested in having him learn to read, we would neither expect the child to see any value in reading nor expect him to have a strong desire to learn to read.

What influences ability to learn?

Both the biological capacity of the child given at birth, and the results of experience, influence ability to learn; but except in extreme cases it is difficult to separate the effects of heredity and of environment. The ability to learn at any particular time in a person's life depends upon that person's hereditary makeup, plus all the experiences he has had up to that time. Therefore, any test of ability to learn—commonly called an “intelligence test”—is affected by these same factors, heredity plus accumulated experience.

Are persons of high intelligence the best learners?

Since by definition “intelligence” means the ability to learn, yes. But because there are many things that can be learned—ranging from reading and arithmetic, through social studies, drawing, and trumpet-playing, to street-brawling, picking pockets, and prostitution, there are many specialized abilities that contribute to the success in one learning task or another. Even if we look only at the learning of school subjects, it is apparent that a somewhat different set of skills is required for learning history from the set required to learn physics. Psychologists recognize that all school learning tasks have a good deal in common; the ability needed for all these tasks is called “general intelligence.” The ability needed specifically for learning mathematics is called “quantitative aptitude” and the ability needed specifically for mastering the more “literary” subjects (such as English, geography, French) is called “verbal aptitude.”

What tests are available to determine learning ability?

A great variety of tests are available to measure learning ability. Most of these tests are designed to measure aptitude for learning school

subjects; they measure this aptitude more effectively than they measure ability to learn to swim, or to learn to sell insurance, or to learn to drive a car. Thus our intelligence tests would more properly be called "academic aptitude tests."

Well-known intelligence tests for children include the Stanford-Binet Scale (named for the French psychologist, Alfred Binet) and the Wechsler Intelligence Scale for Children. A widely used test for adults is the Wechsler Adult Intelligence Scale. All the tests named so far are individual tests of intelligence. (See *Psychodiagnostic and Personality Testing; Aptitude and Vocational Testing*)

Do men differ from women in their ability to learn?

A few women have learned practically anything men typically learn, and a few men have learned things that women typically learn. There are women who are engineers and men who are seamstresses. On the whole, men seem to be better at some tasks and women at others; boys learn science more easily, girls are better at languages; but such differences are probably the result of social conventions that make learning science rewarding for the boy and learning a language rewarding for the girl. There is no evidence that, in general, one sex is more intelligent than the other.

When is the best time of life for learning?

There is no one best time of life for learning; it depends on what is to be learned. The best time to learn to read is after the child has become familiar conversationally with a good number of words, and after he has acquired certain skills in looking at visual displays and in following directions (these skills are called "reading readiness"). The best time to learn analytic geometry is after one has learned algebra, because analytic geometry builds on algebra. The best time to learn administration of a complex industrial organization is after one has mastered the preparatory skills; for instance, after one has learned the manufacturing and distribution procedures of the company and has learned how to work with others as a fairminded supervisor, as a co-operative committee member, or as a loyal subordinate. In general, the best time to learn is when one has mastered the necessary preparatory skills. For some activities this is early in life, for others it is late. In athletic skills, the best time is often early in life, before strength and quickness have begun to decline; for activities requiring judgment and knowledge, the best time is likely to be later.

Does learning alter in the aging process? If so, how?

The learning process remains the same in its principles throughout life. Motivation, cue, response, and reward are necessary conditions for learning at any age. However, the efficiency of learning declines in later life if degenerative changes have taken place in the brain. These changes lead to "senility." Many old people remain as alert and mentally capable as they ever were; most people show some effect of degenerative changes in old age; and a few suffer such severe damage that their condition is called "senile psychosis." Of course, a mentally alert old person may be slowed down in motor coordination and action; and any skill dependent upon motor activity for its effectiveness will be hampered by this slowness.

Do persons with superior memories learn fastest?

Probably not. There is a good deal of controversy among psychologists about whether people who learn fast also remember best; but one can at least say that the evidence doesn't strikingly support the idea that good learning and good memory go together.

What might keep an individual from learning to his full potential?

First we must answer: What is "full potential"? It is not useful to mean by this the biologically-given capacity to learn, as it exists at birth; for from birth onward experience acts upon inborn capacity, producing what we can speak of as "developed ability," i.e., the capability of the person to learn at the later time. The intelligence test score, or I.Q., is a measure of developed ability—not of "native" intelligence.

This developed ability, whether great or small, may be utilized or not. Whether it is used depends, in large part, on opportunities, motivation, and rewards. In the school, lack of motivation to learn is probably the most important cause of students' not learning to their full potential, i.e., to the extent of their developed ability.

Other causes of learning below what is possible for the child are: (1) neurotic disturbances, (2) poor instruction, and (3) poor methods of study.

What are the various methods of study? Which are notably successful? On what does this depend?

Those who write textbooks on how to study agree that no one method can be uniformly prescribed for all students and all subjects. However, common among methods recommended by the experts are

those which permit active participation on the part of the learner, distributed practice, and frequent and periodic review. Active participation implies specific purposes in mind while studying, attempting to see relationships among ideas, and understanding reasons rather than making use of passive and rote memorization. "Distributed practice" is regular study over time. Three two-hour periods during the week will probably lead to more effective learning than one six-hour period on the weekend. Review is necessary for retention. Research upon the most effective methods for complex learning is lacking, but probably the success of any method depends mainly on the motivation of the learner.

What are the elements most conducive to good studying and learning?

Probably the element most effective in good studying and learning is the amount of time spent. Research has shown that reading an assignment twice is no more effective than reading it once, provided the amount of time is constant. Similarly, one learns to ride a bicycle well by spending a great deal of time riding it. One generally remembers a face better than a name because one has spent more time looking at the face than pronouncing the name. Studying may be regarded as planned training for learning in school. As such the same conditions required for any learning—motivation, cue, response, and reward—are the ones which contribute to good studying and learning in school.

What is the relation between learning and the ability to concentrate?

Formal learning in school such as learning to read, learning history, learning arithmetic depends on the ability to concentrate. We will define the ability to concentrate as the ability to maintain attention. Thus, in learning to read the child has to attend to the words. A more advanced student learning algebra has to attend to the explanation given by the instructor. If a person is frequently distracted while studying an assignment, he will not maintain his attention or concentration and the amount learned during that time period will be lowered. Children who have very short attention spans frequently encounter difficulty in learning school subjects.

Can the ability to concentrate be improved? How?

Except in a very limited sense, there is probably no such thing as "the ability" to concentrate. The attention span of children is quite short, but it increases with age. Beyond this, the ability to concentrate

or maintain attention probably depends mainly on motivation and interest. A child who cannot maintain attention in school might be able to spend hours attending to television programs. A college student who cannot concentrate on his studies can concentrate very well while at an interesting movie. We can improve our ability to concentrate while studying by developing an interest in the material being studied. We can also improve our ability to concentrate while studying by removing distracting stimuli, whether external or internal. A blaring radio makes a disturbing external stimulus; worry about personal problems brings disturbing internal stimuli. In general, then, the ability to concentrate does not exist in the abstract. Concentration depends upon the situation and the amount of interest the learner has.

What is the theory of teaching machines? Do they provide an effective way to learn?

The idea behind teaching machines is that scientific knowledge of learning can be used to create a more effective program of instruction. For instance, in any subject the more advanced ideas depend on the more fundamental ideas. A good teaching program will make sure that students learn the fundamental ideas before it presents the advanced ones. A properly "programmed" teaching machine is designed so that students will learn the easier items before they can go on to the harder items. A good program is set up so that the student has a fair chance of hitting upon the right answer (and therefore gets rewarded, since by and large success in learning is experienced as a reward). A good teaching machine requires the student to make a response to each item; and it gives him immediate knowledge of whether the response was "correct" (reward). Thus, the scientifically-ascertained principles of learning are applied to school learning. It should be understood, however, that teaching machines do not—and cannot—provide a human relationship, human contact, and human warmth; and these are essential as a part of the total learning experience of the schoolchild. As was previously pointed out, one of the child's principal motives to learn is to please his parents and other adults. Thus, the teacher has an essential role in school learning, as a motivator and rewarder, whether or not teaching machines are used.

What effect does reading have on the learning of school subjects?

Most school subjects depend upon the ability to read, and if a child is limited in his reading ability, almost all of his schoolwork will

suffer. However, a clear distinction should be made between the ability to read silently and the ability to read orally. School learning depends upon the former. There is little relationship between silent and oral reading ability, and the purposes of each are quite different. The main purpose of silent reading is to receive information. The main purpose of oral reading is to convey information to others. Some studies have shown that the frequency of errors made while reading aloud have little relationship to the understanding of what is read. Thus, a child may not read well orally, but his schoolwork will not suffer because his comprehension of the material is satisfactory.

Why can't Johnny read? Are phonics the answer?

The main reason why Johnny (children in the public schools of the United States) is having difficulty with reading is probably because of the overcrowded conditions in the classroom. That is, the average teacher is faced with too many children for her to be completely effective. These reasons are independent of the method used to teach reading. No studies have been done so far which show that one method of teaching reading is superior to another. The consensus among experts is that a combination of the visual and phonic methods will result in the best teaching of reading. Studies suggest that regardless of the method used the percentage of children who learn to read is approximately the same.

Is reading ability lower today than it was a generation ago?

Studies comparing the reading abilities of different generations have been rather few and have many limitations. Since the socioeconomic level and intellectual level of children who attend a school frequently change over a long period of time, accurate comparisons cannot be made. It is not fair to compare the performance of children who a generation ago represented the socially elite with children in the same school today who represent a different segment of the population. Some attempts have been made to control these social variables, and where this has been done the results show that in silent reading comprehension, the achievement of pupils is approximately the same today as it was a generation ago. In accuracy of oral reading, the children of yesteryear were somewhat better.

There are more children with reading problems in schools today than formerly, probably because there are more children in school. Even the percentage of children with reading problems may be higher today

than a generation ago, but this is probably the result of overcrowded conditions rather than the methods used in teaching. In a large classroom, it is more difficult to meet the needs of individual children than in a small one. Consequently, it would be expected that more children would have difficulty.

What is the scientific basis of courses in fast reading? Can the full sense and understanding of written material be absorbed during extremely fast reading? Is exceptional intelligence needed to master this technique?

There is very little scientific basis for courses in fast reading. Results of evaluative studies of rapid reading courses for college students have consistently shown that students who received such training read considerably faster at the end of the course than they did at the beginning and faster than students who had not received the training. However, most of these studies compared students who had volunteered for the course, while the control group were students who had not volunteered. Consequently, the two groups were not equal in motivation and it is difficult to make statements regarding the effectiveness of the training. The considered opinion of experts in the field of reading is that some rapid reading courses are effective, but satisfactory research is lacking.

The ability to read rapidly depends on many factors, one of which is the ability to comprehend. One cannot read faster than one thinks or faster than one's rate of understanding. Furthermore, the ability to read rapidly depends upon the type of material, the purpose for which it is read, and the degree of familiarity with the content. A child might read *Tom Sawyer* for the enjoyment of the story. One adult might read *Tom Sawyer* for making a character analysis of adolescence. Still another might approach it from the viewpoint of a historical analysis of life on the Mississippi. Each of the purposes would require a different rate of reading. Each would represent a different level and depth of understanding. Extremely rapid reading is probably effective only when the material is quite easy, when the reader is familiar with the content, and when the purpose is to gain superficial information or to understand only the main idea of what is being presented. The full sense and understanding of written material cannot be absorbed during rapid reading.

Exceptional intelligence is not needed to read rapidly, but familiarity with the content and the ability to adjust rate to purpose is necessary.

Are the schools in the United States making use of the potential of their students?

At the present time many scientists, educators, and leaders in government are concerned about the number of capable students who either drop out of school or do not receive higher education. In the past, schools have allocated more money for the training of the retarded and handicapped than for the gifted child. Significant research is now being conducted on the nature of creativity in order that tests may be developed that will aid in the early identification of children who have the potential for making original contributions to human thought. This research is in the initial stages and has made only a limited impact on educational practices. At present, although there are exceptions, most schools do not have adequate facilities or provisions for training pupils of exceptional ability.

How do American students compare with European students in ability and achievement?

Studies comparing European and American high school students have shown that the European students generally have more and different abilities, and have attained a higher educational level. However, it is believed that educational methods and ability of the general population in Europe and America have nothing to do with a difference in achievement; the difference is produced by the restriction of high school education in Europe to selected pupils, whereas in the United States secondary schools are not restricted to a selected group.

What is meant by "progressive education"? Are the teaching methods advocated by "progressive education" effective?

When the term is used accurately, "progressive education" means the principles espoused by John Dewey. Dewey pointed out that teachers must make use of the motives their pupils have for learning, if they are to teach effectively; and that they must bring it about so that their pupils respond actively, if anything is to be learned. The discussion of learning principles in previous paragraphs shows the relevance of Dewey's points.

Many educators misunderstand Dewey's point of view. They believe that the need for motivating pupils makes it necessary for the teacher to teach only those things that the pupil wants to learn; this is not Dewey's suggestion. But certain educators believe that in order to get active response the preferred way to teach is to have pupils engage in

various "activities," such as crafts, dramatics, making scrapbooks, and the like. Dewey did not intend these activities as aims in themselves, nor did he think of such activities as the only kind of active response.

"Progressive education" as understood by Dewey is an effective approach to teaching; "progressive education" as misunderstood by certain other people is not.

LEARNING AND READING DISTURBANCES

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What is meant by a learning or reading disturbance?

From the standpoint of educational problems, a learning or reading disturbance is present when there is a discrepancy between the amount a child is achieving and his capacity for achieving. For example, a child may be slow and be retarded in his school subjects two or three years below the average of his classmates, but if his achievement (the quality and quantity of a student's work during a given period) were in accordance with his capacity, he would not have a learning disturbance; rather, he would be characterized as a slow learner. As another example, if a child in fourth grade reads at a second-grade level, he does not have a reading problem if there is no reason to believe him capable of reading at better than a second-grade level. On the other hand, if a child in fourth grade reads at a second-grade level, a reading problem exists if there are independent reasons for judging him capable of fourth-grade performance. Thus, in the assessment of every learning or reading problem, some estimate must be made of the child's capability or potential for learning, and unless his achievement in school or in reading is below this estimate, he does not have a learning or reading disturbance. A reading problem or learning problem is never said to exist on the basis of achievement level alone.

How can one measure a child's potential for learning?

The best assessment of a child's potential for learning can be made when the type of material to be learned is specified, when the conditions under which the learning will take place are known, when meas-

ures are available of how well the individual has learned in the past, and when appropriate intelligence and other test scores are available and carefully interpreted in light of the past history and socioeconomic level of the individual.

No single measure can be made which will indicate how well a child is capable of learning for all types of material and situations. To measure a child's potential for learning in school, many psychologists and educators use intelligence tests. These are probably the best single predictors of school success, but they may be useless in predicting learning for a situation in which a great deal of mechanical aptitude is required.

When the results of intelligence tests are used to describe a child's learning potential in school, a great deal of caution must be exercised. For example, if a child has limited reading ability, he should not be given a test that requires or involves reading; such a test would underestimate his ability. Some investigations have shown that children from underprivileged homes and low socioeconomic levels are penalized by many of the commonly used intelligence tests. It is important to note that an intelligence test may be inappropriate for measuring a child's potential for learning, but it can be used quite well to predict his success in a given school. For example, if a child obtains a low score on an intelligence test because of a culturally deprived background, the same factors which produced the low score may also result in poor school achievement. Thus, the test might not be suitable for measuring a child's potential for learning in some other school under a different set of conditions, but a good estimate could be obtained of how well he would achieve in his present situation.

In general, the material to be learned must be specified before measures can be made of a child's potential. For certain types of learning—school achievement, mechanical ability, artistic ability, musical ability—tests are available to estimate probable success. The tests have many limitations, but to date no better single measures have been devised. (See *Intelligence Testing*)

At what age can learning and reading disturbances be detected?

Depending on the severity and the type of the problem, school learning and reading disturbances may be detected by the end of first grade. To illustrate: Suppose a child had not learned to recognize any words by the end of Grade I, and yet he was competent in the use of numbers, he had scored high on reading readiness tests, he was above average on appropriate intelligence tests, spoke fluently, and was able

to discriminate between letters and symbols that appear similar; this evidence would be suggestive of a reading problem at a rather early age. However, children vary greatly in the age at which they learn to read even under ideal conditions, and the fact that a child has not learned to read by the end of first grade is not cause for alarm in and of itself.

Some types of problems do not appear until the middle grades. For example, reading in the first three grades depends primarily upon a memorized sight vocabulary. Some children may have the ability to remember words, but they are deficient in sounding out words or in identifying the meaning and pronunciation of words unfamiliar to them at sight. In the middle grades, a child must use his reading in a wide variety of content areas, and he may encounter many new words. Consequently, a child whose overall achievement in reading appeared satisfactory in the primary grades may have been deficient in certain fundamental skills, but the consequences of these deficiencies would not appear until the child reached a more advanced stage of reading.

What causes learning and reading disturbances? What can be done to prevent them?

Inappropriate instruction in the schools is probably the greatest single cause of learning and reading disturbances. That the instruction is inappropriate is not necessarily the fault of the teacher because it may result from an overcrowded classroom. In a large classroom, it is difficult if not impossible to meet the needs of every child in the group. The methods used must be those that will result in learning for the greatest number of children, but they may be inappropriate for some. The shortage of teachers and the large number of children entering school has resulted in hiring many individuals who are inexperienced, which results in poor teaching.

Learning and reading disabilities may also result from a variety of factors independent of the school such as visual and hearing disabilities, glandular disturbances, general malnourishment, frequent absence or changing of schools, and emotional problems. Some evidence suggests that specific reading disabilities may result from minimal brain injury suffered at birth or early in the development of the child. Most reading and learning disturbances are the result of a variety of factors, and for an individual child it is often impossible to say what might have caused the disturbance.

Many reading and learning disturbances could probably be prevented

by obtaining better qualified teachers and by increasing the amount of money available to schools so that children may be taught in smaller groups. Parents can assist their children by creating an interest in learning, providing them with appropriate books, and by reading to them.

What tests are used to detect learning and reading disabilities and where can they be obtained?

Tests used to detect learning and reading disabilities include standardized tests of school achievement, intelligence tests, personality tests, and motor coordination tests, as well as tests of vision and hearing. Many of the tests are available from publishing houses such as the Psychological Corporation in New York City and the Educational Testing Service of Princeton, New Jersey. Since these tests should only be administered by trained personnel, reputable publishing houses will not sell them to private individuals.

What organizations can be consulted about learning and reading disturbances?

Most colleges and universities have clinics for the purpose of conducting research into learning and reading disabilities, for training competent personnel, and for service to the community. In addition, there are many state or municipal psychological or mental hygiene clinics where examinations can be obtained. The particular functions of these organizations differ; however, they all represent sources where reliable information can be obtained.

Do schools have an adequate system for handling children with learning or reading disturbances?

In general, no, but it depends on the school. Some schools and school systems have excellent facilities for working with children who have generalized learning or reading disturbances—particularly the latter—but many schools have none. A problem facing many schools is the critical shortage of personnel qualified and trained to work with children who have special learning and reading problems. In an average classroom, a child who has a severe reading disability usually does not receive much help with his problem. First, the average classroom teacher has probably not been trained to teach children who have severe learning or reading disabilities. Second, children who have severe

learning or reading disabilities generally require individual training or at least instruction in very small groups. To give severely retarded readers the kind and amount of instruction they need, the average classroom teacher would have to neglect the other children in the room.

Can learning and reading disturbances cause other problems?

Whether or not learning and reading disturbances cause other problems has not been determined. For example, many experts believe that as a consequence of failing to learn to read, children will develop feelings of inferiority and show many signs of emotional maladjustment. However, we cannot say that occurrence of emotional problems in children who also have reading problems demonstrates that the reading failure was causative, because the children we happen to observe are seen after an emotional problem had developed, and the reasoning that the reading problem "caused" the emotional problem has been done after the fact. Furthermore, there are many children with reading disabilities who do not show symptoms of other problems.

Certain types of experiments necessary to determine the consequences of learning and reading disturbances have not been done. Few, if any, investigations have been performed to determine whether children who developed reading problems subsequently developed other problems with a higher frequency than a comparable group of children without reading disabilities. Even so, the results would not be conclusive because it might be that the same factors that produced the reading or learning disturbance might result in other problems. (See *Childhood Emotional Disorders*)

Are learning and reading disturbances symptomatic of other problems?

In many instances, psychiatrists and psychologists will interpret the presence of a reading and/or learning disturbance as symptomatic of a more basic or underlying problem—particularly an emotional one—but at times as symptomatic of general physical malaise. Some state that failure to learn to read represents an unconscious attack on the parents, or is the consequence of too much pressure applied on the child. Others have said that failure to learn to read is a way of getting love and attention from the parents or a result of an inner emotional conflict that makes it hard for the child effectively to direct his energies to an intellectual task. While plausible and logical defenses can be made for all these statements, factual evidence obtained within the framework of

sound scientific research is extremely limited in support of any of them. Most statements pertaining to reading and learning disabilities as symptoms or causes of other problems have only the status of questionable hypotheses. The best that can be concluded on the basis of present evidence is that, for some children, emotional, physical, and other problems may cause a learning or reading disturbance. For others, a reading or learning disturbance may cause an emotional problem. For still others, learning and reading disturbances may coexist independently along with other problems. Evidence does suggest that the greater the severity of the reading problem, the more likely it is that one will discover the presence of other problems.

What percentage of children of average intelligence have learning or reading disturbances?

Various surveys have reported that anywhere from 10 to 40 per cent of children with average or above-average intelligence have reading or learning disturbances. The most frequent estimate reported is around 15 per cent. The difference in the results may be explained by the fact that investigations were conducted in different school systems. The criteria and definitions used to determine reading and learning disturbances differed, and the methods by which the samples were selected were not the same. Studies pertaining to the incidence of reading and learning disabilities have been notoriously unreliable and in many instances reflected little more than the personal bias of the investigator.

Do more boys than girls have learning or reading disturbances? If so, why?

In the ratio of about ten to one, more reading disturbances occur among boys than girls. The reason for this fact is unknown. Some believe that the result is due to innate differences between boys and girls. For example, girls learn to talk at an earlier age than boys. Others believe that it may be the result of cultural differences in the treatment of boys and girls. First-grade teachers are usually women, and reading is frequently regarded as a more suitable pastime for girls. Still others suggest that the materials used in the early grades are more interesting to girls than to boys. To repeat, it is a fact that many more boys than girls have reading or learning disturbances, but the reasons for this fact remain in the realm of speculation.

How are learning or reading disturbances overcome?

The first step in overcoming a learning or reading disturbance is to obtain a thorough diagnosis to ascertain the nature of the problem, the capacity for learning, and the presence of factors that may be inhibiting the learning. Only on the basis of accurate diagnostic information can a program be inaugurated that will overcome the problem.

A good remedial program will generally include a plan of individualized instruction carefully adapted to the needs of the child. Specific instruction will be given in the areas of weakness, and the materials will be suitable for the level of achievement and interest. For example, if a fifteen-year-old boy reads at a third-grade level, the reading material should be no more difficult than this, but at the same time it must be appropriate for his interests.

The methods used for teaching children with severe learning or reading disturbances are frequently no different from the methods used in regular teaching. The principal difference is that the methods are adapted to the needs of the individual child.

For remedial instruction in reading, three methods may be described—the visual, the phonic, and the kinesthetic. The visual is often called the “look-and-say” method; the phonic method involves sounding out of words. In the kinesthetic method, by having the child trace a word with his finger while saying it aloud, use is made of visual, auditory, and tactile senses in developing word recognition ability. A competent remedial teacher will use all three methods depending on the particular problem.

There is little to choose among the methods themselves. Their success depends more on the person using them than on anything else. There is some evidence which suggests that, in teaching children who have reading disabilities, the methods used should be different from the ones employed in the original teaching.

When the reading and/or learning disturbance coexists with other problems, the remedial instruction might be done in conjunction with psychotherapy or some form of medical treatment. However, no single method or plan can be described for overcoming learning disturbances, because it depends upon the particular problem.

How successful have various methods been in overcoming learning and reading disabilities? On what does this depend?

Good research regarding the success of remedial instruction has been extremely limited. Individual cases have been reported that have

appeared to respond very favorably to remedial instruction. Experiments pertaining to groups have shown that the test scores were higher at the end of instruction than at the beginning, but it is dangerous to conclude that this is the result of remedial instruction because of the absence of suitable control groups. Studies are lacking in which children who have reading problems are given special training and then the results compared with those obtained from a group of children equal in all respects except for the fact that they were not given training.

While experimental evidence is lacking, the success of remedial instruction probably depends upon a variety of factors including the severity of the problem, the age at which treatment is started, the methods and materials used, the motivation of the child, the competence of the therapist or remedial teacher, and the relationship which exists between the child and the teacher.

Is there a time when treatment for learning and reading disturbances begins too late?

From a practical standpoint, probably yes, but a definite age cannot be specified. The more severe a disability, the longer it will take to overcome. If a child has reached the age of twelve or thirteen without learning to read, there is little probability that he will ever become proficient because of the lack of facilities necessary to train such an individual and the expense involved. This does not mean that an adolescent or even an adult cannot learn to read with appropriate training, but realistically the chances of obtaining the training are not good.

Few experiments have been reported on children who have long-standing reading and learning disturbances, and little is known about the optimal age to begin remedial reading instruction. The safest statement that perhaps can be made is that other things being equal, the younger the child, the greater the chances for success.

What are the significant areas of current research into learning and reading disturbances? How can these studies contribute to better or improved mental health?

Probably the most promising research being made is the attempt to integrate the findings of studies from impaired learners with known principles of learning, in an effort to develop a theory of learning that will explain equally well how people learn and how they fail to learn.

To determine the etiology of learning and reading disturbances, a great amount of multidisciplinary research (cooperation among specialists from different areas—psychology, psychiatry, medicine, and biochemistry) is being done to understand better the interrelationships among kinds of disorders. Intensive investigations on the relationship between functions of the brain and impairment of learning are underway. More and more research is longitudinal in nature, i.e., the same children are being studied over a long period of time.

Equally important is the research on the prevention of learning and reading disabilities. Experiments are being done to ascertain the methods of instruction and the type of instruction necessary to produce optimal learning. Studies of children reared in different cultures should develop a better understanding of how environmental factors influence learning.

Studies of the foregoing type should result in improved mental health as greater understanding is gained of the interrelationship of the neurological, physiological, and psychological processes of the individual, the factors which affect learning, and how these may be modified through training. Among recent trends in education, perhaps the most significant for hygiene is an increased emphasis on interpersonal relationships. Teachers do pay more attention to students as individuals, are more aware of their needs and personalities, and have more respect for them as persons. The recent trend is more explicit recognition of the personal quality of education.

LOVE

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What is love?

Love is the communication to another person of one's deep involvement in that person's welfare, of one's profound interest in him as a person, demonstrated by acts that support, stimulate, and contribute to the realization of his potentialities and fulfillment. From this viewpoint mental health may be understood to mean the ability to love and the ability to work.

Are there different kinds of love?

There are, but only in the sense that they represent different degrees and different forms of the love described above. For example, love of one's parents will differ from the kind of love one has toward one's spouse, and love for one's children will similarly differ, as will love for one's country. But whatever form love takes, its basic pattern and primary origin can be seen in the love that a loving mother has for the child at her breast.

What causes two individuals to love each other?

Two persons love each other as a result of mutual attraction based on a complexity of factors that will vary with different individuals. Physical attraction, personality, and character will, singly or together, trigger off the interest one individual has in another. Children, even those under four years of age, are quite capable of falling in love with adults. Such an early love may become unconsciously fixed, so that thereafter the affected individual is attracted only by individuals who resemble the original love object.

What needs does love fulfill?

Love satisfies the most important of all needs: the need for love. The need to love others and the need to be loved are learned and developed in only one way—by being loved. The child who has not been adequately loved during his first six years becomes an affectionless

character, suffering from "affect-hunger," the need for love. Such a person—as child, adolescent, and adult—not having learned to love, behaves as an unloving individual. He is a "cold fish": insensitive to the feelings of others yet extremely sensitive himself; unable to give affection yet abnormally dependent upon others for affection. The one thing he craves and needs most he does not understand, and since there are few others who understand what ails him, he is unlikely to receive the understanding he needs.

Without love no need can be adequately satisfied. No need can be satisfied by bread alone. It is love that best satisfies the need for fulfillment.

Are all individuals capable of love?

All individuals are born with the capacity for love, but like all other capacities, it requires stimulation and training. The only way one learns to love is by being loved by those who are responsible for one's upbringing. Those most capable of love are those who were most loved in their years of dependency upon others. Children who have not been loved grow up to be unloving personalities, craving love but unable to return it, much as they may want to. The unloved child is the child most in need of love. If he is unlovable, it is because he is in need of love, and the same is true of the unlovable adult.

The answer to the question, then, is that all individuals are capable of love if they are given the opportunity to develop it. Those who have been deprived of the opportunity are usually incapable of love, unless they make a serious effort to learn how to love—a never-ending learning experience that in itself is a kind of triumph. The need for love and the capacity for love cannot be destroyed, even though they can be seriously retarded and deformed.

What are the consequences for the individual who is not capable of love?

The fundamental consequence to, and characteristic of, the individual not capable of love is his inability to relate himself harmoniously and creatively toward others. Not having learned how to love, he is unable to exhibit love. He is lacking in warmth. He is capable of violent, often overviolent, expression of emotion, but is incapable of tenderness in its expression. He is awkward and incompetent in his relations with others and is, therefore, more often than not, considered "difficult." When he offers anyone a token of esteem or "affection," he

does it awkwardly; therefore his overtures are often rejected. Thus, the frustration he experiences because of the rejection of his tentative advances, forces him into the vicious circle of hating those whom he wants to love because he does not know how to love. He is aggressive, selfish, unable to share the feelings of others, and incapable of entering into any but the most superficial emotional relationships. He finds it as easy to divorce as to marry; or because he is so afraid of being left alone, he will cling to his spouse with a complex and aggressive dependency.

This starvation of love shows itself in his emotional emaciation, and in the aridity and one-dimensionality of his feelings. Since the unloved person rarely understands what is wrong with himself, he often behaves as if the rest of the world is wrong and as if he alone is right. When such a person is a powerful political or business leader, such as an Adolf Hitler, the world often tends to take him at his own valuation. But in general, whether such a person is a leader or just an ordinary man, he tends to have a very difficult time.

Does psychotherapy help an individual to experience love?

Psychotherapy is one of the best means by which the individual who has been injured in his capacity for love may learn to recover the ability to love. In the psychotherapeutic situation, the individual may transfer to the therapist all those emotions that he should have devoted to his parents or other possible loved ones. In the psychotherapeutic situation, the individual intensively and insightfully comes to understand and to experience the satisfactions and acts growing out of the exchanges with the therapist, which in turn, lead to improved relations with others. The individual may, as a result of this therapeutic situation, be able to undergo reciprocal exchanges with an essentially loving person and therefore recover the ability to love.

Does adult male-female love require sexual relations?

The only general answer that can be given to this question is that it all depends on the individuals involved. Love between male and female does not necessarily imply or require sexual relations. In our culture, unfortunately, love is too often identified and confused with sex, so that persons thus confused find it impossible to think of a love between male and female that doesn't involve sexual relations. Nevertheless, a very tender, loving relationship can exist between a man and a woman without sexual relations playing any role. In other words, it is possible to love enduringly a member of the opposite sex without hav-

ing or desiring sexual relations with that person. It is, of course, also possible to love with a sexual desire but without its fulfillment.

Adult male-female relations imply a certain amount of maturity, and one of the marks of maturity is an ability to govern oneself; another is the ability to postpone immediate satisfactions for long-term aims. Within such a context of maturity, whether love results in sexual relations or not is ultimately a matter between the individuals.

What is a "platonic relationship"?

A "platonic relationship" is usually understood as a relationship of close friendship with a member of the opposite sex—without the involvement of sexual relations.

If "sexual attraction" is defined as interest in another, initiated by his or her stimulus value as an object of sex, then it is quite possible to love a person of the opposite sex without any element of sexual attraction entering into the picture. If the term "sexual" is understood as equivalent to what Sigmund Freud described as "libido," meaning the whole available energy of the love drive—and this concept is a debatable one—then love of anyone involves a sexual component. This may well be the case if sexuality is understood in this generalized sense. Every form of love would, therefore, to some extent be sexual, that is, sexual without acts or interest directed toward sexual relations.

Can one love a member of the same sex without homosexual overtones being present?

Untold numbers of men and women have loved members of their own sex without the slightest homosexual overtones or undertones being present. Many of these men and women would be revolted by any such suggestion; others would be amused. Again, in the implication that a sexual element must be present in love, there is the confusion between love and sex. Just as sex is possible without love, so love is possible without sex, or the slightest sexual interest in another—male or female. Of course, the love of some individuals for members of their own sex may have homosexual overtones, but from this or any other of the facts of life it does not necessarily follow that such an element is present. (See *Homosexuality*)

Is it possible for one individual to love another without reciprocation?

Yes. It is not only possible for one individual to love another without reciprocation, it is a relatively common occurrence. After some time

this becomes the situation in many marriages. But although love is possible and, indeed, desirable without the demand for reciprocation, the person in love does desire that reciprocation. Love by its nature is unconditional, and is freely and unreservedly given. It is neither an article nor an instrument of barter. The only way that one can stimulate the development of the ability to love in those who lack this ability, is by teaching them how desirable it is to love, even without reciprocation. It should always be remembered that the individual most in need of love is not the most lovable, but the most unlovable. The only way in which the nonreciprocating, unloving individual can ever be recovered for reciprocating love is by being loved. Success with such individuals may take years. To love a nonreciprocating individual, frustrating as it often may be, is nonetheless in itself a highly rewarding experience, for it tends to evoke the best qualities in oneself and also, eventually, in the other.

What is needed to maintain love?

The requisites for the maintenance of love are (1) involvement in the welfare of another, (2) loyalty, (3) acceptance of another with all his faults as well as his virtues—without condoning the faults of the other, taking delight in him, not for what he ought to be but for what he is, and (4) a willingness not only to put oneself in the other's place, but also a desire to improve and make that place as happy as possible.

One of the things that is *not* a-requisite for the maintenance of love is sex. It is necessary to emphasize this point because the belief is widespread that love, particularly in marriage, is incompatible with unsatisfactory sex relations. This is another example of the confusion between love and sex. Many married couples discover that although sex may be important in marriage, it has very little to do with love or the maintenance of a loving relationship with anyone. Those who have married solely for sex have not married for love—even though they may mistakenly call love and sex by the same name and believe that they are the same thing. These people are likely to find themselves out of love when sex wanes or becomes unsatisfying. Sex may very well enrich a relationship, but it is by no means an indispensable condition to the maintenance of a loving relationship.

Is the second or later love ever as strong as the "first real love"?

How lucky, on the whole, for those concerned that the "first real love" did not result in marriage! One's "first real love" having been

one's "first great love" may well have made a deeper impression than anything similar experienced before or since. But this is not to say that every "first love" is like that, or that having left so deep an impression it is necessarily any deeper or more real than later love. One's "first real love" is usually immature, violent, and consuming, and one may take a long time to recover from it.

Later love is seldom as strong as one's "first real love," and that is an advantage, for the function of one's "first real love" is to steady the individual for a more balanced approach to later, more mature, and more comprehensive love.

What are the psychological and physiological characteristics of love?

The different forms of love have varying psychological characteristics. In general, all of them are characterized by a feeling of deep interest in, and affection for, the person or object loved. Physiologically, love involves changes primarily in the nervous, glandular, and muscular systems. It has been remarked from time immemorial that a person in love simply "glows," "blooms," and "has never been so vital, healthy, or happy." All observation confirms this, as well as the fact that rejected love does the opposite and can lead to a "broken heart." The latter expression is not a mere metaphor, for it is based on common human experience.

The physiological states resulting from the suffering that accompanies rejected or unrequited love may actually lead to shock and circulatory disturbances that may not only be felt as cardiac discomfort, but may even lead to cardiac failure.

Love, of whatever intensity or duration, is a happy feeling-state, and those who are, for example, more or less constantly in love with life, whether they are consciously so or not, are likely to be the happiest people. Such a feeling-state helps to keep them in physiological as well as psychological good health. (See *Emotions*)

What causes one to love an idea, object, or thing rather than to hate it or to dislike it?

In general, we tend to love that which gives us deep and meaningful pleasure—persons, objects, or ideas. But what will elicit profound and meaningful pleasure differs with the individual, depending upon his background, education, and experience. For example, an individual who because of his unlikable traits evokes dislike in one person may, because of the same traits, elicit interest and affection in another. The

latter responds to what he considers to be the need for love, and it gives him pleasure to recognize that need, and to be able to minister to it. (See *Morals, Values, and Mental Health*)

What is spiritual love? How is it developed? How can "love of mankind" be explained, or "love of nature," or "love of God"? Does this love fulfill a need? Can one live a healthy life without feeling some sort of spiritual love?

Spiritual love can be devoted to ideas, objects, persons, events, or deities. It is love as the essence of being directed toward the essence of its object. It is love from which every element of the material and the utilitarian has been removed, and in which the dominant motivations are harmonic, worshipful, supplicatory, sacrificial, and compassionate. Love of country, for example, comprises all these elements, and so does love of mankind, of nature, and of God.

The ability to experience spiritual love is developed in much the same way as is the ability to experience every other form of love, namely, by training, and training rather more by example than by precept, and more at home than at Sunday School.

It is as an agent of spiritual love that man grows beyond himself. The necessity of spiritual love is as deep a need in him as is the need for nourishment. "Man doth not live by bread alone." Man needs to love mankind just as mankind needs to love man, and whether we subscribe to the belief that "God is love" or that "Love is God" will not matter very greatly, so long as we act upon the understanding that man's love must extend beyond himself to embrace the world outside himself. Without such a projection of one's love one cannot live a healthy life, because health implies a balanced satisfaction of needs, and one of the profoundest of these needs is the need to transcend oneself and relate oneself creatively to the universe, and as far as it is reasonably possible, to everything within it.

Can love ever be destructive to oneself? To others?

Genuine love can never be destructive to oneself or to others. It is the one thing in the world of which it is impossible to give anyone too much. There are in the world a great many forms of spurious or counterfeit love—of unloving love, of heartlessness behind the show of love—but these are often the false faces and disguises worn by hostility or indifference.

Genuine love can only be enlarging, creative, supportive, and warming. It can only build, it cannot destroy.

Is some love of self necessary to optimum mental health? Can love of self lead to mental disorder?

Some love of self is necessary for optimum mental health. The care of anyone begins with *caring for* him, and this applies to oneself no less than to others. An individual who had no love for himself would be in a very bad way. All persons have some lovable qualities. Most persons can recognize lovable qualities in themselves, even if few others are able to do so, and can approve of themselves at least for those qualities. But the person who feels that he has no qualities of which he can approve, and who dislikes or tends to be indifferent to himself, becomes alienated from that response in himself which should most closely bind him to others—the ability to love. The individual who does not love himself will, to a large extent, be unable to love others.

Genuine love of self can lead only to optimum mental health, but, an abnormal concentration of interest on and affection for oneself can certainly lead to mental disorder. There must be a balance between love of self and love of others. To the degree that a person fails in the one, he will fail in the other, and to the extent that he thus fails is mental disorder present. (See *Ego*)

MANIC-DEPRESSIVE PSYCHOSIS

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What is manic-depressive psychosis?

This is the name given to a group of mental disorders that most typically show alternating periods of elation (excessively "high" mood) and depression. In some patients only the elated periods occur, and in others, only the depressed periods. In almost all cases the periods of mental disorder alternate with periods of good health. (See *Psychoses*)

What are the symptoms of the manic attack?

The period of elation may be mild (hypomania) or marked. In the milder form, the patient is usually more active and more talkative than is his wont; he is often cheerful, energetic, and smiles at everything. He has a gleam in his eye and a general air of liveliness that may make him appear most attractive. But as one continues one's conversation with him, one notices that he becomes impatient and irritable, and unable to stay on one topic or track of thought. He is full of plans, but quickly abandons each to embark on another—often in quite the opposite direction. He is fully oriented and clear in his speech—no delusions are seen. If this condition goes on to true mania, each of the foregoing processes becomes markedly exaggerated—the patient's ideas come so rapidly that they are no longer coherent; he is extremely overactive, is constantly in motion, and cannot rest; his sleep is disturbed. He may be extremely irritable, going suddenly from a jovial mood to an angry one, and his judgment is poor.

It is thought that the manic attack represents a way of warding off underlying feelings of depression and despair by resorting to activity.

What are the symptoms of the depressive attack?

Depressions, too, may range from mild to severe. In the milder state, the patient is listless, indifferent to what goes on about him, and sluggish in his responses. He appears dull and is often somewhat withdrawn. Everything seems to be an effort for him; he tends to slide into

the background and wants to be left alone. Appetite may be poor; he may be constipated; and although he falls asleep at night, he tends to wake up very early in the morning. Typically, his mood is more depressed in the morning than it is in the evening. In more severe states, he is frankly depressed, even tearful; he feels that he is worthless and not fit to associate with others. He may believe that he has committed a grievous sin or that he has harmed others. He may feel that his body is wasting away. He feels that he should die to atone for his sins. Some patients show an agitated response rather than a sluggish one, and are constantly in motion, pacing the floor, wringing their hands, and keeping up a steady stream of self-reproaches and despairing remarks.

How frequently does manic-depressive psychosis occur?

As is the case with most diagnostic categories of mental illness, the statistics on the incidence of manic-depressive psychosis are not very reliable. However, it is estimated that approximately 10 per cent of all persons admitted to mental hospitals for the first time have a manic-depressive illness. Figures for the milder forms that do not require hospitalization are even less reliable, but it can be definitely stated that they are more numerous than the cases that get to hospitals.

What is its cause?

There is no simple cause to be pointed out in this condition. It is generally believed that a complex set of factors is involved. These include inborn temperament, a wide variety of environmental factors, and often some kind of precipitating event.

Is it inherited?

There is no clear-cut proof that manic-depressive psychosis is inherited. Although it occurs in a higher percentage in families with a manic-depressive parent, it is possible that undesirable experiences in early childhood play an important contributing role.

What are the inborn temperamental factors?

There is some evidence that people who develop manic-depressive illnesses are more likely to belong to the pyknic group of individuals than are those who develop schizophrenia. That is, they are muscular and rounded and tend to be robust, energetic, and intelligent. In personality they tend to be more extroverted or outgoing, more

friendly, more down-to-earth or practical than the slender, easily fatigued, dreamy, asthenic individuals who are thought to be more likely to develop schizophrenia. (Manic-depressive personalities and families are often contrasted with those of schizophrenics because many of the research studies that have been done have used these two groups for comparison. It would be more advantageous, of course, if the mentally disturbed group could be contrasted with an average normal group.)

What environmental factors may be important in causing manic-depressive psychosis?

As with all the emotional disorders, there is much evidence to show that the child's earliest experiences play an important part in forming his personality and in determining his ability to adjust well to the various challenges of childhood and adult living. In general, undue anxiety in childhood, overdiscipline, overindulgence, and rejection are some of the important unhealthful influences.

Families of manic-depressive patients have been found to be often overconcerned with social approval and with raising the family's social prestige. This leads to the child's being overdependent on approval from authorities and also to his being intensely competitive and concerned about success. As he strives for success, he fears the envy of others, and as he fails to reach his goals, he envies others more successful than he. Rather than maturing into a person of independent judgment and self-reliance, he tends to remain a child in his need for an approving kind of closeness. He is then vulnerable to any threat of abandonment or loss of the relationship with those upon whom he is dependent. He is overconscientious and fearful of his own hostile or aggressive feelings and tends to blame himself when anything goes wrong.

What kind of precipitating event is likely to bring about an attack of manic-depressive psychosis?

It has long been known that many attacks follow upon the loss of a beloved person. This is seen in all kinds of depressions. Sometimes the loss is not very obvious, that is, it may be a psychological loss rather than a death. Estrangements, quarrels, moving away, separation through marriage, and many other similar events may be responded to as a loss. At times the loss is not that of a dependent relationship with a loved relative, but may be the loss of some important relationship at

work. For instance, it sometimes happens that a person becomes depressed after receiving a promotion. In such cases, what has been lost is a relationship of dependence on a superior at work; in the new position the person may be faced with responsibilities that he feels unequal to, and he may react as though he were now alone and helpless. (See *Depressions*)

How can the family of a manic-depressive patient recognize the disorder?

The diagnosis has to be made by a psychiatrist. However, the sudden appearance of severe depression or of severe elation in a young adult would be cause for concern and would indicate that a visit to a psychiatrist would be important.

Is this a serious illness?

Yes, it is. Both the current illness and the dangers of recurrence make it serious. In the manic phase, the patient has poor judgment and is likely to engage in activities that may lead to regrettable consequences. An example would be that of engaging in a spending spree that would create a serious financial burden, or suddenly making an impulsive marriage. In the depressive phase, not only does much misery accompany the condition, but there is also danger of suicide. In addition, the family has to face the fact that these attacks, whether of manic or of depressive character, tend to recur. In the present state of our knowledge, this cannot always be prevented; however, learning how to live with and most effectively manage the illness can be helpful.

Is it necessary for the patient to go to a hospital?

It frequently is necessary, but not always. The decision to hospitalize the patient depends on how severe his illness is and also on what the facilities are for his care at home. The situation must be carefully evaluated in a conference between relatives and a psychiatrist. If manic behavior is beyond control and is rapidly leading to the patient's exhaustion, then hospitalization is imperative. Also, if depressive behavior leads to complete self-neglect and refusal of food, or if suicide is attempted or seems seriously threatened, the patient should be hospitalized. Sometimes symptoms are less severe; then with adequate nursing care a patient may be kept at home. This is made more possible if he has a good therapeutic relationship with a doctor.

How is manic-depressive psychosis treated?

A discussion of the treatment of this condition must necessarily be only tentative and sketchy, since a great many factors must be taken into account. Some of these are the patient's age, the severity of the illness, the number of times he has been ill, the kinds of conflicts that have played a part in the illness, and so on.

A plan for treatment will differ, in the case of a patient who is young and who is having his first attack, from the treatment recommended when the patient is middle-aged or elderly and has already suffered from many relapses. In the first instance, the greatest emphasis would be put on an effort to help the patient achieve insight into the psychological conflicts that were responsible for his breakdown, in the hope that some changes in basic attitudes and ways of meeting conflict situations would render future attacks unlikely. On the other hand, a more elderly person might be evaluated in terms of how much flexibility and capacity for personality growth he has, and treatment would be planned accordingly.

There are two approaches to the symptomatic treatment of the depressive phase of the psychosis: the use of drugs and the use of electroshock therapy. Both of these external agents can relieve the symptoms of depression in a large percentage of cases. Present practice in many large hospitals is to try the new drugs (which belong to the class of medications popularly known as tranquilizers) first, and in those cases where the drugs are ineffective to use electroshock. When either of these treatments is effective, it is necessary to realize that the procedure has relieved the symptoms but has not necessarily done anything about the cause. If the symptoms spring from some serious malfunctioning of the personality, they will recur unless the cause is found and treated appropriately. It is for this reason that every effort needs to be made to combine the external therapy with psychotherapy.

In the case of the patient in the manic phase of the illness, electroshock therapy is rather ineffective, and here drugs are used with the goal of calming and quieting the patient to the point where he can use his own intelligence and good judgment in the effort to understand and resolve the conflicts that have sent him into the manic escape. (See *Psychopharmacology*)

There is another school of thought in regard to the treatment of the manic-depressive psychoses, which holds that the use of both drugs and electroshock are undesirable because they treat only the symptoms, not the cause. This group advocates the use of intensive psychotherapy

without the use of the other agents. The number of patients for whom such therapy is available is limited, because of the factors of time and expense. However, there are other therapeutic approaches also available, such as group therapy, brief therapy, and family therapy, which can be useful and effective. The goal of all of them is to assist the patient to uncover conflicts and to alter basic attitudes that have led to his maladaptation. As he does so, he can hope to better his relationships, increase his ability to endure and cope with emotional stress, and achieve that internal balance or integration that we call emotional maturity.

Both research psychiatrists and practitioners are constantly striving to increase their knowledge of human behavior and improve their skills in treating the emotionally ill. And every effort ought to be made by patients and their families to break the chain of recurring attacks by utilizing psychotherapy in the intervals between attacks as well as during them.

What are the patients' symptoms in between attacks?

In between attacks manic-depressive patients are not distinguished from average normal people except by the very subtle personality factors already mentioned.

Can people who have had an attack work, marry, have children, and lead relatively normal lives?

Yes. They can and do. Sometimes further attacks of psychosis do not occur at all; sometimes life itself has a maturing influence on the person; sometimes a new relationship, such as a successful marriage, provides the security that is needed to prevent further trouble.

How can the family of a manic-depressive patient be helpful?

During the illness the family can work closely with the psychiatrist. It is often necessary to arrange to have someone be with the patient continually if hospitalization is to be avoided. There will be other specific measures to be taken, varying with the patient. In the healthy intervals, everything one can do to help the patient build a full and satisfying life containing rewarding activity and good relationships will be useful. Close relatives can help by refusing to go along with the person's overconscientiousness, tendency to blame himself, and fear of his own angry feelings. On the other hand, excessive cheeriness and

attempts to coax the patient out of his depression are both futile and irritating to him.

In child rearing are there any preventive measures that may help avoid the development of manic-depressive tendencies?

It is a truism that a healthy and happy childhood is likely to lead to a similar kind of maturity. Parents need to know themselves and their children and to react to their children as persons in their own right, rather than as little reproductions of themselves or as instruments through which their own unfulfilled wishes can be realized. This is not to recommend either overindulgence or timidity in reasonable exercise of parental authority. Rather, respect for the child and help to him in developing along his own lines are likely to make a constructive atmosphere for him. (See *Parenthood and Child Rearing; Child Development; Childhood Emotional Disorders*)

MARITAL PROBLEMS AND MARITAL ADJUSTMENT

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What are the most frequent problems that disturb the functioning of a marriage, but do not necessarily lead to divorce?

Problems of many different kinds may be cited as the immediate cause of marital difficulties—money, sexual maladjustment, in-laws, children, infidelity, etc. However, the problems essentially complained of fall within the broad category of lack of consideration by one spouse for the other. The lack of consideration may be in the handling of money—selfishness about money or failure to support; it may be in the area of affection and sex—failure to respond or perform adequately sexually or undue demand or withholding; it may be in the area of work or recreation—overactivity which leaves out the spouse or laziness in meeting responsibilities; it may be in ineffectual communication or complete absence of attempt to let the partner know what is going on. But essentially, the basic complaint is that a person fails to consider his spouse's feelings, needs, values, and goals, or acts in disregard of them.

Failure to meet the other partner's preconceived ideas of how a husband or wife should act, and failure to agree with his standards of behavior or value systems, i.e., the idea that the other is "different," with difference interpreted as "undesirable," may cause misunderstanding and difficulty. Any difference from one partner's preconceived ideas of how his spouse should function in marriage may be regarded

as a failure to perform satisfactorily or in a socially acceptable way and may be considered an affront by the other partner.

How can marriage partners adjust to differing temperaments, desires for socializing, values, ideals, etc.?

Basic to adjusting to different temperaments, desires, values, and ideals is an acceptance by each partner of the right of the other person to be different, and a willingness to work out a compromise in terms of the long-run welfare of the marital unit—rather than a demand that one's own expectations and happiness come first.

For example: Mrs. Brown may desire to continue with her career after marriage, because her feelings of achievement and self-worth are closely tied in with her career. Mr. Brown may feel that his wife's first responsibility is to her home and children, and may expect her to discontinue her career. It is quite possible that a solution satisfactory to both can be arrived at through part-time work, with Mr. Brown lending some support and help with the home and children. Mutual willingness to consider the feelings of the other may not resolve the conflict, but it makes for an environment where a resolution of conflict is possible. There are several elements involved in resolving a conflict—first, ability to communicate with each other with the expectation that the communication will be listened to and be understood; second, ability and willingness of at least one partner to make concessions; third, understanding and support by each partner of the other's efforts to make a change in expectation and behavior.

How can jealousy become a problem in marriage?

The concept of monogamous marriage is emphasized in the ethics of Christianity and Judaism and is reflected in the laws of the United States. Therefore, when either partner steps over the culturally prescribed limits of marital fidelity, it is to be expected that anxiety and resentment on the part of the other partner will ensue and is or might be interpreted as jealousy.

Jealousy, not founded on fact, is the outward manifestation of a deep insecurity of the jealous partner in his or her sexual role and in his or her concept of self, especially in the capacity to evoke and keep the affection and fidelity of the other partner. Often this leads to attempts to limit or control the behavior of the partner with inevitable hostility, doubt, and fear in the jealous spouse, so that a destructive spiral may be set up between the partners.

Is selection of friends (separate and mutual) often a problem in marriage? How should husband and wife attempt a solution?

Selection of friends may, but need not, be a problem in marriage. Marriage essentially links two networks of friends, and marriage partners with ability to establish good personal relations, gradually get to know each other's friends. In general, in compatible marriages, people who appeal to one partner appeal to the other partner also. The sexes differ substantially in their interests, and each partner has need for both individual and joint friendships. Separate friendships and activities threaten a marriage only when they absorb too great a proportion of a person's leisure and interest. The question is one of balance. Difficulties may arise when either partner, out of personal insecurity, feels threatened by the other's friendships, or if there exists a misconception about "togetherness" in marriage, leaving no room for diverse interests and activities. The mutually held group of friends may be enlarged as each tries to share his individually held friends with the other, and through joint activity in community and church groups.

How can the division and spending of money become problems? How can husband and wife adjust to this problem?

Individuals develop their attitudes toward money from their early home associations, and money can mean very different things to different persons. To one person the accumulation of money may represent emotional, as well as practical, security; to another the control of money may represent power; and to yet another it may reflect dominance in the family, etc. If the individuals' attitudes are relatively healthy, money problems may be solved by setting up a mutually acceptable budget and bank account that represent the operating funds of the new unit—the marriage. Whether the money is in a joint bank account or in separate accounts, and how the various types of financial indebtedness are handled, are unimportant provided the method is mutually agreeable and practical. If one system proves impractical, open-mindedness by both partners toward revision is of great assistance to marital harmony.

How can either individual's dependence on, or dislike of, certain relatives become a problem?

A wife's overdependence on her parents may provoke frustration for her husband, who may feel that decisions are never made by him-

self and his wife, but by the wife and her parents. If this situation continues, anger is aroused because the wife seems to care more for her parents than for her husband and the marriage. A similar situation may arise between a husband and his parents. If a marriage is to be successful, it is essential that the partners separate themselves from the child role in relation to their parents and accept an independent, adult role, both in their marriage and with their parents. In some situations where a person has remained dependent on his parents, therapeutic help may be necessary for him to achieve reasonable independence.

However, it is also important for the small nuclear family to have connections with the larger kinship groups, and for each partner to have some willingness to accept and adjust to, and at times even to implement, the need of the other to maintain adult contact with the larger family groups.

In *Modern Introduction to the Family*, edited by Norman W. Bell and Ezra F. Vogel, the nuclear family is defined as "a structural unit composed, as an ideal type, of a man and woman joined in a socially recognized union and their children. Normally, the children are the biological offspring of the spouses, but as in the case of adopted children in our society, they need not necessarily be biologically related. This social unit we shall call the nuclear family or simply the family."

Which books do you recommend for information on the problems of adjustment to marriage?

Listed below are a few books that have been helpful in our work at the Marriage Council in Philadelphia. There are many other excellent books dealing with various aspects of preparation for, and adjustment in marriage, in any well-stocked public or university library.

- 1) *Facts of Life and Love*, by Evelyn M. Duvall
- 2) *Toward a Successful Marriage*, by James A. Peterson
- 3) *Being Married*, by Evelyn M. Duvall and Reuben L. Hill
- 4) *Love and Marriage* (revised edition), by F. Alexander Magoun
- 5) *The Happy Family*, by John Levy and Ruth Monroe
- 6) *Man and Wife: A Source Book on Family Attitudes, Sex Behavior, and Marriage Counseling*, edited by Emily H. Mudd and Aron Krich
- 7) *Sex Life in Marriage*, by Oliver M. Butterfield
- 8) *Sexual Harmony in Marriage*, by Oliver M. Butterfield
- 9) *Marriage Manual*, by Hannah M. and Abraham Stone

- 10) *Sex Attitudes in the Home*, by Ralph G. Eckert
- 11) *The Dynamics of Aging*, by Ethel Sabin Smith

Is it possible to estimate an individual's readiness (including maturity of outlook) for marriage?

The most important considerations that have to do with readiness for marriage are the degree of psychological maturity attained by each partner plus the way in which each individual's needs, temperaments, social background, and values mesh with those of the intended mate, according to James A. Peterson in *Toward a Successful Marriage*. Physical health and the adequacy of approach to love and affection are also important aspects of readiness. There are definite criteria of maturity that may be utilized in assessing readiness to assume an adult role in marriage. Inventories and projective tests for ascertaining the degree of maturity of an individual have been prepared by various authors. One such outline, in *Marriage for Moderns*, edited by Henry A. Bowman has specific reference to maturity for and in marriage. An individual may utilize this outline to study his own degree of maturity and that of his intended mate. However, it is our conviction, based on clinical experience, that the attitudes, values, and goals, and the abilities, skills, and daily performance level of each individual concerned (as these interrelate with the partner), are of major significance.

What may cause major crises in marriage and when are they most likely to occur?

What may precipitate a major crisis in one marriage may be handled adequately by the partners in another. The first year of marriage is a year of new adjustments for both partners, and depending upon their maturity and temperament may be completed without undue stress, or, on the other hand, may foment serious problems. The largest number of divorces is reported in the first year of marriage, the next largest number in the third and fifth years. Adjustment to the role of parent, in addition to that of husband and wife, imposes additional strain. How severe the strain and whether or not the birth of a child may be disrupting to the marriage depend upon the marital stability of the couple and their readiness for the responsibilities of parenthood. (See *Parenthood and Child Rearing*)

What are the special marital problems of the working woman?

Special marital problems of the working woman depend in the main upon the individual situation and the attitudes of the husband

and wife concerned. Generally speaking, questions of overfatigue, pressure, and strain from attempting to carry two functions, and resentment toward necessity for employment, might all be anticipated. In a study of working wives by Artie Gianopulos and Howard E. Mitchell ("Marital Disagreement in Working Wife Marriages as a Function of Husband's Attitude Toward Wife's Employment," as elaborated in *Marriage and Family Living*, Vol. XIX, No. 4, November, 1957), it was found that the wife's working became a problem only when the husband did not approve. When both the husband and wife approved, the fact of the wife working in itself did not constitute a problem. Eleanor E. Maccoby, in a study, "The Effects Upon Children of Their Mothers' Outside Employment," concludes, "Some mothers should work while others should not, and the outcome for the children depends upon many factors other than the employment itself."

What are likely to be the problems of a marriage between individuals of different religions? Races? Economic levels? Age levels? Educational levels?

Marriage requires an adjustment of the feelings, attitudes, behavior, ideas, and value systems of the two individuals. Anything that creates a great discrepancy in any one of these factors may intrinsically place greater stress on the adaptive resources of the partners.

People are not just individuals, they are members of groups, and in any marriage between individuals of different groups both intrapersonal and interpersonal pressures exist. The strength of the pressures will vary from individual to individual, depending upon the degree of identification each partner has with his own group. In some situations, the inner ties may be minimal, and only external or social involvements conflict; in other situations the outer group involvement may be minimal, and the inner identification strong. Partners of divergent backgrounds bring conflicting values, expectations, and behavior into marriage and hence have less common ground on which to build. More consistent effort is therefore necessary to establish a mutual basis of understanding and functioning. When troubles arise, the sense of difference magnifies the difficulty. Insofar as the partners remain tied to their own groups, the solidarity of the marriage is threatened. When children come, the question arises as to which group they shall be reared in, and any resolution involves either compromise, or renunciation by one partner. "Mixed marriages" are vulnerable to all the usual in-law problems, and their resolution is more difficult.

In interclass marriages, it is usually the woman who marries upward. Studies have shown that this type of marriage is, on the whole, less successful than homogamous ones. However, when the wife holds the higher position, an even greater strain is placed on the marriage because the wife tends to assume the husband's social position in the community. The husband may feel a constant strain to "get ahead," may resent financial assistance from his wife's family, and may feel both inadequate and inferior, and thus handicap his capacity to cope successfully with career and work situations.

Mixed marriage involves greater psychological strain; and the greater the disparity between group identifications, the greater the potential problems and effort necessary to bring about a satisfactory adjustment.

How does great friction in marriage affect the child?

A child's basic need is for a feeling of love and security. Where parents are continually quarreling, the child's sense of security may be adversely affected, both by fear of the breakup of the home and because of divided loyalties. It is difficult for a child to live in a situation where he needs the support and affection of both parents, and where one parent may try to use him against the other, or may try to secure his loyalty, with the result that he feels guilty toward the other parent.

How does one parent sometimes use a child as a weapon against the other parent?

Parents who are having marital difficulties are often adept in mobilizing a child's anger or fear against the other parent. Frequently, a parent may suggest to a child that the other partner will leave home unless the child is a "good" child, or behaves in a particular way. Obviously, if more trouble ensues the child thinks he is responsible for the difficulty and feels guilty. One parent may subtly indicate that the other parent is "cranky," "mean," "stingy," etc., with an idea that the child will, therefore, turn to him or her for affection and loyalty. Children may be used by the mother as a means of extorting additional financial outlays from the father. If the father refuses or is unable to meet the demand, the deprivation to the child of whatever he may have wished, may be attributed to the father. Often a child is threatened with the displeasure of the absent parent if he does not comply with some request or if he misbehaves. If separation or divorce threatens, one parent may use contact with the child as a means of controlling the other's actions and decisions.

Could some problems in marriage be eliminated if women were to marry men younger than themselves?

In his studies of the sexual behavior of the human male and female, Alfred C. Kinsey indicates that the peak of orgasmic sexual outlet occurs at very different ages for the two sexes—in the male usually between the ages of eighteen and twenty-two, and in the female between the ages of thirty and thirty-seven. Thus it might appear that a woman in her thirties would have a better sexual adjustment with a man between the ages of eighteen and twenty-two. There are, however, many other factors to consider in marriage. Culturally and traditionally, it has been the accepted custom for men to marry women considerably younger than themselves. This partially had its origin in the days when it was necessary for a man to establish himself economically before he could assume the responsibilities of marriage. It was also related to the higher death rate of women in past generations during their childbearing years, with the consequence that a man might have had several wives. There is a trend at present for couples to marry within a narrower range of age difference—usually from two to five years—with the male the older. In terms of present values held for marriage—companionship, affection, children, and a way of life in the community—couples tend to choose mates within the same general age decade. Nowadays, the acceptance of marriages in which the man receives financial help from his parents or his wife enables men to marry at a younger age. (See *Sexual Relations and Marriage*)

Why does it seem that problems begin when one individual in a marriage becomes famous or successful? Does one individual sometimes "outgrow" the other?

There are many marriages where one partner becomes famous, and the other partner adjusts to the situation and may in fact be one of the bulwarks that enables the "famous" partner to achieve and function. In some instances the achievements of one partner may enable the other to bask with comfort and delight in reflected glory. In other situations, one partner may grow beyond the other in achievement, learning, or sophistication and the difference creates discomfort and unhappiness for both. Where the wife outstrips the husband it is obvious that in a culture which is still close to the patriarchal, the feelings of competition and frustration would in most instances be more intense than where the husband outshines his wife. Obviously, there

are differences in capacity to learn and to achieve, and differences in motivation, and frequently in the opportunity to grow and change. The adjustment made, in each instance, would depend upon the individuals involved; it might be to separate, to divorce, or to accept the difference and live with it, perhaps even to enjoy it.

Do marriages have a better chance for success where the partners have distinctly different personalities and interests rather than where there is a similarity of personalities?

In all societies married couples are found to have many characteristics in common, particularly those status characteristics that are structurally central in that society. Marriages are likely to be more stable if the partners have somewhat the same conception of the role of each in the marriage as well as similarity of personality characteristics and interests.

Each person brings to marriage a need for maintaining his own identity and a need for a complementary relationship with another. Where there are great differences in personality and interests, the problems involved in adjustment to each other are inevitably greater and demand more of each partner than in a marriage where like interests and like values lend themselves to easier adjustment and complementarity. A study, "Impressions of Personality as a Function of Marital Conflict" in the *Journal of Abnormal and Social Psychology*, Vol. 47, No. 2, April, 1952, undertaken by Malcolm G. Preston, William L. Peltz, Emily H. Mudd, and Hazel B. Froscher indicates that when partners in marriage each feel that they love each other and feel that the marriage is happy, they rate their partner (or a list of personality characteristics) as more like themselves than do partners who rate themselves as unhappy in their marriage. This happens whether or not the self-ratings of each partner are more or less similar. It can therefore be seen that realistic differences of the kind referred to in this question might tend to promote and sustain stress and even conflict.

Is a marriage headed for trouble if one partner is psychologically dependent on the other?

There is no one pattern of marriage that is essential for a satisfying union. There is reason to believe that the choice of a marital partner represents the merging of many needs and motives. When a person approaches marriage, he is likely to select a person who seems

to meet his needs on both an unconscious and a conscious level. The quality of satisfaction in a marriage is closely related to this meeting of each other's need. Whether the marriage can weather the adjustments necessary when children arrive depends to a large extent on how each partner has been able to develop into a more independent individual, to readjust to the changed configuration of the family, and yet to maintain needs that the other partner could meet to some satisfactory degree.

Is a marriage due for trouble if one partner insists on complete responsibility or if one partner refuses to take part in the responsibilities of the marriage?

It would seem improbable that a marriage of this kind could exist without conflict and disintegration. Marriage assumes a certain mutuality of satisfactions, duties, functions, and responsibilities. If one partner insists on assuming complete responsibility for decisions, budgeting, child spacing, etc., it demotes the other person to the role of an object; he is no longer an equally participating adult. At this point the partner thus treated has no opportunity to express his individual needs and preferences within the marriage relationship and is faced with acceptance of the role of a child, or with frustration and conflict. Conversely, if a person refuses to take part in the responsibilities of marriage, he or she is functioning at the level of the child who expects to be cared for and wants to make no decisions. This, too, almost inevitably creates anger and frustration for the partner.

Do late marriages create fewer problems than early ones?

This is a relative question; "late" would need to be more clearly defined. There is evidence that in very early marriages, teen-age as compared with those entered into a few years later, the partners tend to show less understanding and less sympathy for each other's needs and problems. In American culture, persons under twenty are also more likely to be both emotionally and economically still partially dependent on their parents. This then involves divided loyalties and involvement of six rather than merely two persons in the marriage—surely a complicating factor in adjustment. William J. Goode, in *After Divorce*, found that the average marrying age for the divorced group was substantially younger than that of the "married once only" segment of the general population.

What are likely to be the problems in a marriage where one partner is dedicated almost exclusively to his work, and his family comes second in his time, interest, and consideration?

The problems that arise in this type of situation depend, to a large extent, on whether or not the man's conception of his role in the marriage coincided, or conflicted, with the conception held by his wife. One of the cultural values in the United States is a demand for activity that results in accomplishments. In the medical, religious, and scientific fields, a work dedication that places the family in a secondary position is quite common, and members of the family tend to recognize this as a universal factor and to adjust to it. This implies a value orientation to, and identification with, the particular kind of work by both the man and the members of his family. In other situations where career and business pressures are great and the burden of maintaining the marriage and rearing the children falls on a wife whose value orientation and identifications are dissimilar, anger and frustration often result. The particular problems depend both on the personalities involved and the specific situation. Loneliness, frustration, feelings of deprivation, anger at too much one-sided family responsibility, difficulty in the management and discipline of teen-age children, difficulty for the children in relating comfortably to masculine or (if the mother works) feminine figures could arise.

What problems are likely to arise when a man's work takes him away from home frequently and for long periods?

The problems of any married couple must be understood in terms of their mutuality and the interdependence of the particular family role adaptations. The values sought in marriage are satisfaction of sexual needs, reciprocity of emotional and social companionship, the sharing of authority, and a division of labor.

Emotional loneliness, lack of companionship, individualized and overburdening responsibility, as well as the unavailability of the sexual partner may all create dissatisfactions and conflicts. Vulnerability to involvement with persons outside the marriage is inevitably increased. Boredom for the man who must spend long hours in the impersonal atmosphere of hotels, and for the woman confined to the home with young children, is an added problem. Each couple must find individual solutions. Frankly facing together the difficulties and deprivations inherent in the situation for each one, emotional sharing, and understanding can do much to mitigate the situation. Decisions regarding

independent social activity should be made jointly and be based on consideration of each other's feelings and attitudes. When possible, the man might arrange to take his wife with him on trips to conventions, etc., to reinforce their relationship as husband and wife.

What are likely to be the problems of the career girl who marries and gives up her job?

"Career" girl implies that much of the woman's sense of self and identity has been found within her career, and that one of her basic values has been in accomplishment in her career. Moving into marriage and giving up her job will mean a period of major adjustment because she will be faced with a reevaluation and reintegration of what constitutes her value and worth as an individual. In addition, she will be faced with increased household tasks—probably working alone—that often appear to carry less long-range challenge and satisfaction. Problems of boredom and loneliness, and of the "waste" of education, are frequent complaints heard from this group of young women as they attempt to adjust to becoming wives and homemakers. Actually, contemporary conditions indicate that the choice between marriage or a congenial career is no longer necessary. Historically there has been a dramatic increase in employment of women outside of their homes, usually on the basis of economic need. Robert O. Blood, Jr., in his book, *Marriage*, states that the following is the emerging life-cycle pattern of the employment of married women:

- 1) Nearly all wives are likely to work after marriage until their first pregnancy.
- 2) Very few mothers of preschool children (mostly hardship cases of severe economic necessity) will work even part time away from their children.
- 3) When the last child enters first grade, employment will rise sharply and continue to increase until the last child leaves home or reaches adulthood, when employment will reach a second peak.

The impact of the wife's employment on the marital satisfactions of both husband and wife therefore depends on the balance between accruing gains, in terms of less strain financially; losses, in terms of house-keeping and mothering time; and changes in division of labor within the home. All these variables are influenced drastically by whether the husband's attitude is favorable or unfavorable toward his wife's employment.

What are likely to be the reasons why either partner would seek outside sexual interests?

It has come to be an accepted fact that there is a two-way cause and effect relationship between sex and the rest of marriage. Success in marriage does not rest on a satisfactory sexual relationship alone, but on many other factors. It is hoped that in marriage a couple may be able to integrate the sexual and nonsexual aspects of their relationship into a deepened sense of belonging and security, which involves the whole of their personalities. The capacity to do this depends not only on the reciprocal relationship between the partners but also on the relative state of maturity of each partner. Prior to marriage, being in love is a state of mind that tends to idealize and overestimate the loved one, to overlook or minimize faults or flaws, and to satisfy the need we all have for an uncritical and all-embracing love. When the couple goes on into marriage, reality must be faced, and unless each partner has the capacity for integrity and responsibility in the handling of frustration and the acceptance of differences, fidelity in all areas is threatened. (See *Courtship and Engagement*)

Cooking, cleaning, financial responsibility, are a far cry from the early illusions of being "in love," and as irritation, dissatisfaction, and frustrations increase, there may be a search for another "all-giving" love. In every marriage critical times will come to threaten the relationship. As the man's energies are taken up more with his job and a woman's attention with childbearing and caring for children, one or the other may feel deprived or rejected, or as if he or she does not matter. Unresolved immature longings become more insistent, and either partner may seek a relationship outside of marriage hoping to find a "more understanding" or "more giving" partner. Usually this kind of behavior has its roots, not in mature capacity for sexuality, but in the areas of unmet childhood needs for love, receptivity, and dependency. In marriages where one partner has a mature capacity for love and the other has remained at a childish stage of development, such outside interests are more likely to occur. Sometimes they are absorbed within the marriage framework with resultant difficulties. Sometimes they lead to the decision to end the marriage. (See *Emotional Problems of Divorce*)

Why does either partner in a marriage seek excessive outside interests?

When marriage partners seek excessive outside activity, it might reasonably be assumed that they are finding their life together unsatis-

factory, and are using this form of activity as an escape and essentially as an "emotional divorce." In attempting to understand the reasons for the difficulty, it would be necessary to assess the particular marriage and the individual partners. It could be that either partner (or both) is finding continuous dissatisfaction in the marriage, but that neither wants to run the risk of actual dissolution because the relationship is of some real or potential value.

What factors in marriage could cause the partners to reach the point where "they no longer have anything to say to each other"?

Breakdown of communication between partners is frequently one of the first symptoms of a disturbed marital relationship. Communication is not only an exchange or interchange of thoughts and ideas. Communication that brings about true understanding conveys not just thoughts, but the feelings behind the thoughts. To be aware of someone else's feelings, we must be able to recognize our own and have the courage to discuss them. In every marriage there are anger-provoking situations. Resentments grow and build. When, because of fear of anger, fear of ability to control anger, or hopelessness in making the other understand, anger is repressed, denied, or blocked off, it gradually builds a wall between the two partners, so that each essentially feels he or she has nothing to say to the other. (See *Marriage Counseling*)

MARRIAGE COUNSELING

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What is marriage counseling?

Marriage counseling is defined as the process through which a professionally trained counselor assists two persons (the engaged or marriage partners) to develop abilities in resolving, to some workable degree, the problems that trouble them in their interpersonal relationships as they enter into a marriage, live with it, or move out of it. The focus of the counselor's approach is the relationship between the two people in the marriage rather than the reorganization of the personality structure of the individual as it may be in psychiatric therapy.

How is it distinguished from other therapies?

The essential distinguishing factor is the emphasis in treatment on the interpersonal relationship, instead of focusing on the individual's inner adjustment. Marriage counseling services represent many different points of view and are offered by persons with varied experiences and training, including religious leaders, physicians, psychologists, social workers, educators, and in specialized agencies. Differences within the professional groups offering marriage counseling are related to their specific disciplines, which determine to a large degree their conceptions of human relationships, their orientation to marriage, the aims or goals of marriage counseling, and the kind of help that is made available to the marital partners. Specifically, marriage counseling clients, in most instances, are seen once weekly, face to face, where conscious feelings, attitudes, and situational factors are dealt with. In

addition, in most instances, both partners are seen individually and occasionally jointly by the same counselor. All professions engaged in marriage counseling, despite their other commitments, have in common a sincere concern with helping people in emotional distress. The methods by which they hope to achieve this purpose may differ, but this basic concern remains constant.

What are its aims?

There is an essential agreement on the goals of marriage counseling—to help individuals or partners to come to some resolution of their conflicts and difficulties in order that they may achieve more adequacy in dealing with their problems, a greater capacity for suitable mate selection, and increased competence in interpersonal relationships.

What is its history?

Marriage counseling has probably existed in some form from time immemorial, but marriage counseling as an expression of our particular time and culture is different in several ways: specifically, in (1) the type of help sought; (2) the resources utilized for help; (3) the training of the individual counselor; and (4) the attitudes of the individuals counseled concerning entering into marriage, living within it, and its termination.

Formerly, when difficulties arose, couples turned naturally to family, friends, and relatives for advice, or to the family doctor, the religious leader, or the wise within the community. Although today as earlier in this country, help from the family physician, the religious leader, or the wise may be sought, it is the professional and scientific element in the individual discipline of the helping person, along with his personal warmth and support, that is the quality desired, rather than the informal assistance sought in previous generations. Furthermore, the older members of the family, who in many instances functioned as comparatively informal counselors, now often distrust their capacity to help the younger generation.

What is new in the twentieth century is the conscious application of our knowledge of human behavior and personality development, derived from the findings of psychoanalysis, clinical psychology, child development, and cultural anthropology, to the problems of living. It has become almost a cultural "imperative" that individuals or couples should seek "objective professional" help when trouble arises in a marriage or before applying for a divorce. There is only the beginning

of interest evident in exploring, at the courtship and premarital stage, what might be done to promote more adequate and constructive selection of marital partners. A very considerable evidence of the application of knowledge of child development to try to promote emotional health in childhood and youth is apparent, however.

What are the major emotional or psychiatric problems with which marriage counseling deals?

Individuals or partners seeking counseling fall into two main groups, the premarital and the postmarital. Often the previously married individuals, whether widowed or divorced, may seek counseling on a premarital basis before entering into a second marital union.

The fundamental difficulty underlying marital conflict is the individual's inability to relate constructively to his or her partner because of inappropriate selection, unresolved conflicts, or residual immaturities. The focus of conflict may be in many different areas, e.g., fear, ignorance, and misinformation, as well as varying degrees of heterosexual inadequacy, including impotency, frigidity, homosexuality, and many sexual variations. There are many conflicts resulting from the attempt to break emotional ties to parents, from parental disapproval of choice of mate, from infidelity, separation, divorce, reconciliation, alcoholism, infertility, health difficulties, and interreligious or interracial marriages. With the growth of courses in education for marriage and family living in schools, universities, and colleges, and the publication of a varied selection of excellent books on love and marriage, there is a decrease in the number of young people who seek purely factual information concerning the sexual side of marriage from counseling services.

What other factors are involved in marital conflict?

Differing cultural or ethnic groups have varying concepts of the husband's and wife's role in marriage. The conscious values sought in marriage today—affectional response, companionship, equality, and opportunity for individual self-expression are part of the fabric of modern life in the United States. Often, however, individuals move into marriage unaware of their conflicting values and assumptions about marriage. On the one hand, they may be committed to believing in the traditional ideal of marriage—marriage to the partner of one's choice on the basis of romantic love with the expectation that marriages so made will be monogamous and endure throughout the life of the partners. Conversely, each partner may be equally committed to believing

in his or her right to freedom for individual achievement and personal happiness, and in the right to terminate the marriage if it fails to provide these values, on the assumption that it is the choice of marital partner that is "wrong."

For modern couples, the idea that marriage is terminable has, except within some religious groups, permeated the concept of marriage, and the threat of this may become a verbalized or un verbalized part of every serious quarrel. Moral and religious sanctions have become relative rather than absolute for many couples and the use of these older sanctions no longer offers the same degree of outer control and stability to marriage; nor does economic dependence on the male any longer control the actions of large numbers of women.

As a result of these changes, many marriages depend for their stability and permanency upon the ability of the partners to harmonize their mutual wants and needs to a satisfactory degree. Thus, the emotional adjustment between the marital partners must bear a large part of the burden of holding the marriage together. It is when this marital interaction begets chronic unhappiness or breaks down, that the present-day couple, recognizing that the continuance of a mutually comfortable and supportive marriage depends upon a satisfactory relationship to each other, turns to some outer source for help.

Are there emotional or psychiatric problems which arise during marriage counseling?

Certain people are first conscious of extreme disappointment, anger, and emotional disturbance in the daily adjustment to the marriage relationship. Others suffer from physical symptoms, the origin of which cannot be discovered by routine medical examinations. The majority of these persons hesitate at this stage in their problem to resort to psychiatry. Experience has indicated that nine out of ten such couples who have marital problems and who come for counseling can be treated through counseling, and that approximately two-thirds of this group can obtain some degree of relief and can learn methods of resolving their difficulties. The tenth person can usually be persuaded to accept referral for psychiatric treatment.

What is the relationship between marriage counseling and the psychiatric therapies?

Adequate marriage counseling facilities, in which emphasis is on knowing what not to undertake as much as what to undertake, offer

services that supplement those of psychiatry. Such facilities deal with troubled persons at incipient stages in their difficulties, or when the difficulties, although of long duration, have not yet produced mental illness. Because marriage counseling contacts are brief compared with the length of average psychiatric treatment, the individual cost is substantially less even when psychiatric supervision is maintained. Since 66 per cent of counseled cases show improvement, it appears that marriage counseling can offer a service auxiliary to that of psychiatry toward the mental health of the community.

What are the chief characteristics or processes of marriage counseling?

There is general agreement that the relationship between the client and the counselor is the important medium through which help is given and the process of problem solving and change take place. It is recognized that "change" for the troubled and anxious person lies not in what is done to him or for him, but in the degree to which he can derive something from the new experience in relationship that meets some of his needs for acceptance, for emotional nurture and support, and at the same time stimulates him to reexamine his ways of feeling, thinking, responding, and through this widens his perspectives, resolves some of his conflicts, and modifies the behavior and attitudes that have been destructive to the marriage relationship.

The counselor may use various techniques. These include psychological support (encouragement, reassurance of strengths, and development of new perspectives); the draining off of excessive anger or hostile feelings; clarification of conflicts, and help in dealing with guilt and anxiety; at times direct information and guidance; and assistance in re-opening or strengthening verbal and emotional communication between the partners. Occasionally the client's way of relating to his partner that occasions difficulty is interpreted to him with the expectation that he wants to change and may be able to do so. However, as contrasted with psychiatric therapy, unless the counselor is also a psychiatrist or trained psychotherapist, there is usually no attempt made to work with marital partners on the basis of preconscious or unconscious material, nor is there an attempt to help the client achieve insight into his deeper sources of motivation.

Marriage counseling has as its primary concern an understanding of the way in which each partner projects his attitudes, feelings, wants, needs, and daily behavior into the marital relationship. It is not enough for the counselor to understand each marital partner as an individual

only; a psychosocial understanding of a marital problem involves an understanding of the way in which each partner functions in the interacting relationship that is the marriage. It is within this interaction, as each partner tries to gain satisfaction of his or her needs, that a balance is created to support and complement the other partner—or to produce a destructive and conflicting relationship.

Because this interacting relationship plays such an important role in marital adjustment, marriage counselors in many instances counsel both partners. In certain other professional approaches in which marriage problems may be a factor, as in psychiatric treatment, each partner is often seen by a separate therapist.

If both husband and wife seek counseling are they seen together or separately?

Because the interacting relationship plays such an important part in marriage, counselors in many instances counsel both partners individually and, at times, together. Although certain hazards are involved, there are definite advantages to the appropriate use of joint interviews. Both individual and joint interviews are usual in the initial or "intake" period of counseling, the joint interview emphasizing any feeling of unity the partners may have at the outset, thereby giving the counselor an opportunity to observe how they interact with each other. As counseling proceeds individually, occasional joint interviews may be indicated to clarify points on which there is disagreement, or to furnish the partners, through discussion and cooperation, some experience in problem solving. This may be the first wedge in re-establishing constructive communication between them. A final interview with both partners tends to solidify gains and to enable them to support each other as they begin to function without the help of the counselor.

How many types of professional persons participate in marriage counseling?

It is estimated that the major bulk of marriage counseling in the United States is handled by the minister, priest, or rabbi. Help may be sought also from the family physician, the pediatrician, the gynecologist, the internist, and the psychiatrist by many of their patients. Social agencies, especially those offering family service, in some areas indicate as much as 60 per cent of their case load to be marriage counseling. As yet, comparatively few of these professional persons

have acquired additional specialized training or supervised experience for this work.

Some of the members in the American Association of Marriage Counselors use marriage counseling skills within their private practice, others in hospital clinics, social agencies, university counseling services or centers organized specifically for marriage counseling.

What special training is required for marriage counselors?

Requirements for trained personnel have increased as marriage counseling has acquired professional recognition. Recognized services initiated since 1950 report that all staff personnel have a minimum of a master's degree, and many hold a Ph.D. or an M.D. Most services have physicians and psychiatrists in consultant or supervisory positions. The American Association of Marriage Counselors in 1956 appointed a Committee on Standards and Training to explore existing facilities and to recommend standards for training. An unpublished report of this Committee in 1958 states, "Specialization in marriage counseling, as an adjunct to other disciplines, necessitates that . . . the counselor have a knowledge of human growth and development, and of the dynamics of human behavior and human motivations; a capacity to differentiate between normal and abnormal behavior mechanisms; and some understanding of the everyday give-and-take problems of family living and relationships within the family group. In addition, the marriage counselor needs to be skilled in the use of basic counseling techniques, and to have developed a disciplined control of his own biases, prejudices, attitudes, and needs as these may affect his work with clients."

Is there certification of marriage counselors?

Although certification has been discussed by the Board of Directors, to date there has been no official action recommended by the American Association of Marriage Counselors or any other private or state group known to the authors for professional certification or state licensure of marriage counseling.

Are there organizations of marriage counselors?

At present there is only one national organization exclusively concerned with marriage counseling. This is the American Association of Marriage Counselors, with offices at 27 Woodcliff Drive, Madison, New Jersey.

The purpose of this organization, as stated in its bylaws, is:

To establish and to maintain professional standards in marriage counseling. This purpose shall be furthered by meetings, clinical sessions, publications, education and training, and research in this field.

To cooperate with other organizations and agencies in furtherance of these ends.

To take all legitimate action in furtherance of the foregoing purposes.

To carry out the foregoing purposes solely for beneficent purposes and entirely without pecuniary gain, benefit, or profit to the association, its members, officers, or directors.

There are at present six categories of membership: Life Member or Life Fellow, Fellow, Member, Associate, Associate-in-Training, and Affiliate.

Regional groups of the national association have been formed in several geographic areas and more are in the process of formation.

In 1958 the association published *Marriage Counseling, A Casebook*. This book illustrates and implements one of the original and continuing aims of the association, the achievement of perspective, new skills, and insights for the members through the exchange of clinical information and the pooling of experience. It includes one case each from forty-one members of varied professional backgrounds serving in different sections of the United States.

How many people are served by marriage counselors?

It is impossible to give any accurate estimate as marriage counseling is an adjunct to many disciplines, such as medicine, social work, the ministry, and clinical psychology.

Are the available marriage counseling facilities adequate?

This question cannot be answered offhand because adequacy of facilities would, of necessity, cover several different facets, i.e., number of facilities and geographical distribution in relation to population, available staff in relation to demand for service, accessibility in terms of fee, and most important, the professional adequacy of the counselors in terms of professional training and skill.

Present indications suggest that in the next few years developments

in this field may be rapid throughout the world. It is important that, in the effort to provide new services quickly, high standards of practice will not be neglected.

How does the individual contact a marriage counselor?

Friends, relatives, professional individuals, other organizations, and agencies refer clients to marriage counseling facilities. Sometimes knowledge of the resource occurs through attendance at courses in marriage and family relations in schools, colleges, churches, and community groups. Articles in journals or newspapers, television and radio programs, may bring clients to the agency. Other clients find a listing in the telephone book. Within the younger, upper educational and occupational groups, the individual or couple, having been exposed through education to the possible advantage of scientific or psychological help with problems of adjustment, may be self-referred. Increasingly referrals come from friends who have been clients and who feel they have profited from this experience.

Is marriage counseling undertaken in clinics or guidance centers?

As a result of the widely prevalent concern with the breakup of marriages and with evidences of unhappiness and disharmony in marriage and its repercussions on the children involved, a great many professional services offering marriage counseling have developed.

These services represent many different points of view and are offered by persons with varied experiences and training—religious leaders, physicians, psychologists, social workers, educators in university counseling centers, specialized agencies, and private persons.

Is there a fee for such counseling?

This differs with the different resources. In many instances fees are charged, usually on a sliding scale based on income, while in some others, such as pastoral counseling, no fee arrangement is made.

How is marriage counseling supported?

Support of these services has come from the sponsoring groups. Where this group has membership in the local community fund, sums are allocated through this source. In some cases, sponsors raise funds through contributions or memberships. Medical, religious, and university sponsors allocate funds from their own budgets. The majority of services charge a fee for individual and/or group counseling. In the

fee-charging clinics a certain proportion of clients are accepted without charge on the basis of the recommendation of the referring service. Other clients are charged as little as fifty cents an interview, or up to as much as \$25.00 or more, with the majority falling between \$3.00 and \$7.00. Fees seldom cover more than half the cost of the service. A very few of the older services have obtained grants from government and private foundations for research and in-service training.

Is marriage counseling undertaken in mental hospitals?

Marriage counseling, as a specific service, so far as we can learn, is not offered in mental hospitals. Undoubtedly, marital problems may be discussed by the therapist as part of the patient's problems in adjustment to living.

Are there programs for education carried on in connection with marriage counseling?

Realizing that education has a responsibility to prepare people for marriage, many colleges and universities now offer courses in marriage and the family.

There has been a general increase in the whole field of education for marriage and family life. In some communities adult education programs are doing a good job of helping people to understand their marriage difficulties. Even some of our progressive secondary schools are now becoming aware of the value of preparing their students for marriage and are offering courses designed to assist them in building a happy family life.

Clinics where a couple about to be married can come for consultation are already being established in many larger cities. Psychological tests help them somewhat in analyzing their personalities, and counselors point out where differences in personality are likely to cause trouble.

How does marriage counseling serve the purposes of general research?

Research in recent decades by sociologists and psychologists is exploring and occasionally modifying our concepts of the family and its individual members. Social work and psychiatric research have dealt primarily with clinical problems focused on the pathology of the individual and on the efficacy of various therapeutic processes with little emphasis on these disturbed individuals as interacting members of a family group. Little has been done in marriage counseling research in

terms of concentrating on the intricacies and specific patterns of interaction between marital partners, the dynamics of marital interaction, the effect of troubled marriages on the children or family group, and the processes or techniques that might be most helpful in these situations.

Based on current studies, what might be predicted about the methods and scope of marriage counseling in the near future?

The American Association of Marriage Counselors, in their book (1958) edited by Emily Mudd, Abraham Stone, Maurice Karpf, Jr., and Janet F. Nelson, emphasized several areas in which additional work is needed as part of a program to prevent marriage disorganization. Among these were: (1) an increased emphasis on family-life education that begins in the home and continues throughout school days; (2) development of counseling associations and medical services for all stages of family need; (3) development of more adequate training facilities for the counselor of tomorrow who needs to be "well grounded in the psychology and sociology of marriage and human relations, in the anatomy and physiology of sex, as well as in the skills and tools of counseling"; (4) additional research geared to "development of a theory of marital interaction and family living that would be cultural in perspective and from which a more adequate philosophy of the practice of marriage counseling might develop."

MASS HYSTERIA

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What is mass hysteria?

"Mass hysteria" is a term loosely used to refer to group activities, or transient states of mind shared by a group, which are characterized by constriction of attention, intense emotion, and serious lack of critical judgment. In few instances do participants actually become victims of the chronic psychiatric illness known as *hysteria* or of any other mental disease. Rather, members of the group temporarily lose voluntary control of emotional and rational functions and permit a leader, or the group itself, to suggest to them their emotions, thoughts, and actions. These emotions, thoughts, and actions are not necessarily alien to the members of the group, but they are dissociated from other emotions, thoughts, and actions which normally play a part in the individual's decision-making processes. Thus a group in the throes of mass hysteria may, without compunction, feel, believe, and do things which the members, as individuals, would hesitate or refuse to feel, believe, or do under ordinary circumstances. Behavior under mass hysteria is not necessarily unrealistic, uninhibited, criminal, or depraved; but it can be so and frequently is. The victim of mass hysteria may be compared to a person under *hypnosis*. He has entered a trance-like state in which he will, within limits, believe, feel and do what he is told by the group or the leader. Whereas the professional hypnotist is a responsible person, the group leader (or the group itself) may be irresponsible and destructive in its intentions. (See *Hysteria; Hypnosis*)

What are the main types of mass hysteria?

Mass hysteria takes five main forms, all of them apparently known in most urban, and many pre-urban, cultures (although the content of the hysteria is, of course, specific to the individual society). "Escape panic," which may occur when many persons attempt to flee an overwhelming danger via restricted or narrowing exits, is one of the most ubiquitous and least patterned forms of mass hysteria. "Mobs" have been a common feature of human history for thousands of years,

rioting, brawling, lynching, looting, burning, and in general reacting to frustration with irresponsible destruction. "Religious ceremonials" often depend on inducing mass hysteria in the communicants, as in the old-fashioned western American revival camp meeting, in Haitian "vodun," in the Greek mystery rites, etc. "Political rallies," like religious ceremonies, also at times depend on techniques of inducing mass hysteria for their effectiveness in mobilizing people behind a leader and his program. And finally, mass hysteria is sometimes deliberately induced in a group in order to facilitate unrestrained "mass enjoyment," whether of sex, of music, or of other pleasures, by effecting a general and uniform, but temporary, release of routine inhibitions.

What causes mass hysteria?

Two conditions are necessary for a mass hysteria: a receptive "suggestible state" in the members of the group; and a repeated uniform "suggestion" to the group.

The suggestible state can be induced either by physiological or psychological factors or both. Among the physiological factors may be mentioned drugs, including alcohol; fatigue; sensory deprivation; and rhythmical and monotonous sensory stimulation, as by drumming and singing (comparable to the hypnotist's oscillating point of light). Psychological factors contributing to suggestibility are a high level of suppressed fear or other intense emotion already present in the members of the group; a prior willingness or unconscious wish to accept suggestions from this group or this leader; and a prior willingness or unconscious wish to accept the specific suggestions made.

The uniformity and repetition of the suggestion can be and frequently are ensured by an astute leader, working with confederates, who deliberately undertakes to put the group into a suggestible state and to time the repeated suggestions so as to exert maximum effect. Even without planning, uniformity and repetition are often ensured by the group itself, both by ritualizing the leader's suggestions (as in chanting responses) and by the very closeness of informal contact among members of the group who hear, see, and touch each other, and in so doing multiply the frequency of suggestion.

What are the legal responsibilities of individuals who are part of a group that commits crimes under the influence of mass hysteria?

The individual participant in a crime committed by a group under the influence of mass hysteria is legally responsible for his

actions. He cannot plead that another person was the instigator or leader, or that he was suffering from a mental disorder, or that he was acting under orders.

Is a leader necessary in order to create mass hysteria?

A single leader is not necessary; a group can work itself into mass hysteria by mutual suggestion (as in escape panic). But very commonly in the other types of mass hysteria a single leader assumes or is given the responsibility for making the uniform, repeated suggestion to the group.

What are the qualities of such a leader?

Leaders who are effective in producing mass hysteria are difficult to identify in advance. They are not necessarily persons of high prestige; nor are they necessarily brilliant or proficient in oratory, or physically or morally attractive. A necessary component seems to be a strong sense of personal conviction in the leader that his suggestions are correct, together with a high degree of "fit" between the leader's suggestion and the latent wishes of the group.

What kinds of groups are most susceptible to mass hysteria?

In general, the groups most vulnerable to mass hysteria are unorganized crowds of persons jammed into close physical proximity. Highly organized, differentiated, disciplined groups with good morale and a sense of purpose are resistant to mass hysteria (unless the purpose of the group itself is to enter into mass hysteria, as is the case in some religious and political exercises).

How can individuals resist becoming victims of mass hysteria?

Principally, by being aware of the conditions which induce the suggestible state and avoiding them. No particular social category is especially resistant; at least, age, sex, and intelligence seem to be irrelevant, but some persons are, by reason of temporary circumstances, physical constitution, or psychological makeup, probably more vulnerable to suggestion. As long as the individual is able to avoid the suggestible state, however, he will be able to maintain critical judgment and emotional control and thus be able to resist the suggestions made by the group or its leader.

Should wartime chauvinism, concentration camp atrocities, juvenile gang fights, racial discrimination, and other kinds of undesirable group behavior be attributed to mass hysteria?

Not necessarily. It is possible for one group to follow a policy, or maintain customs, which another group regards as gravely mistaken or even as perverse, for reasons other than mass hysteria. Such reasons may be differing local customs and standards of right and wrong; actual mental pathology; and the ruthless, or even criminal, pursuit of selfish interests.

Is it possible for an entire nation to be ruled by mass hysteria?

No. A nation cannot function if its population is unable to attend to a diversity of needs, to control emotion, or to exercise critical judgment. Because a group suffering from mass hysteria is unable to control emotion, exercise critical judgment, or even attend to interests other than those few immediately represented in its restricted field of intense emotion, it cannot operate the extensive technology and social organization of a modern nation. But it is possible for a nation to subscribe to a delusional doctrine which was suggested to its population in a series of hysterical, political, or religious rallies.

Are "gang psychology," "mob psychology," "crowd psychology," or "group psychology" the same? Are they forms of mass hysteria?

These terms refer to different but overlapping classes of phenomena. A gang is an organized group with a goal, often criminal, which it works more or less rationally to achieve. A crowd may or may not be the victim of mass hysteria; most crowds, most of the time, are not hysterical. The term "group" is all-inclusive, and there are many different kinds of groups—work teams, combat units, professional associations, religious congregations, athletic teams, movie audiences, etc.; and each group can exhibit a variety of different psychological processes. Mobs are often the victims of mass hysteria but not all mobs are necessarily hysterical. In general, one can say that mass hysteria is only one kind of psychological process or state to which groups are subject. Social psychology, which studies group behavior, describes many kinds of psychological process other than mass hysteria. (See *Social Psychology*)

Is it possible to provoke feelings and emotions in a mass that do not exist in the individual?

No. But when the individual is part of a large group, it is possible—as in mass hysteria—for the individual to give expression to feelings and emotions which he would ordinarily suppress or even remain unconscious of under normal circumstances.

Does a feeling of loneliness and a desire to be part of a group impel the individual to join the mass?

There are many motives which draw people to mass situations. Loneliness and a desire to be a part of a group may impel some; others are stimulated by curiosity, by the desire for excitement, and by a half-conscious wish to give vent to repressed feelings under the circumstances of anonymity and group approval.

Is it possible for an individual to be unaware that he has become part of a planned hysteria?

Certainly. Unless he is sophisticated enough to recognize the techniques employed, he may easily believe, or be persuaded, that the hysteria was a spontaneous expression of feeling on the part of the group.

What emotions are most successfully provoked in the crowd?

The nature of the emotions most successfully provoked will depend, of course, on the nature of the crowd, its longings, and needs. In general, it would seem that simple, direct, and powerful emotions like fear, hate, and love can be most readily aroused, provided suitable objects are provided for their outlet, and provided the moral approval of the crowd or its leader is expressed.

Does economic insecurity make one more or less susceptible to mass hysteria?

Any sort of insecurity probably makes one more vulnerable to suggestions regarding the source and removal of the insecurity. Economic insecurity (e.g., wage reduction) would make one more susceptible to a mass hysteria focused on economic reform. Religious insecurity (e.g., fear of damnation) would make one more susceptible to a mass hysteria focused on salvation.

Are persons with mental disorders more susceptible to mass hysteria than others?

No substantial evidence is available to answer this question satisfactorily. Probably persons with severe mental disorders, such as schizophrenia and manic-depressive psychosis, are less susceptible than others, because of their prevailing tendency to withdraw from group situations and to avoid intense emotional commitments to other persons.

Can visions and delusions be held in common by a crowd?

When a crowd is in a suggestible state, the leader can readily persuade people to see and hear things which are not evident to the senses, and to believe what is manifestly not true.

How is it possible that a crowd can accomplish such an act as murder, though for the participants, as individuals, such a crime would be impossible?

It is sad but true that many persons who are kind, respectable, and self-controlled under ordinary circumstances nevertheless harbor, more or less unconsciously, violent and hostile feelings. In mass hysteria, these feelings can be dissociated from the rest of the personality, which normally keeps them under control, and directed toward a scapegoat who serves as a symbol of whatever it is the individual hates and fears.

What sways an entire community to accept, or join in, a reign of terror such as the Salem witchcraft trials?

If a community already believes in the existence of a certain class of enemies, such as witches, it is not difficult to intensify the fear associated with the belief, and, when the community has reached an easily suggestible state, to persuade it to extreme and irrational action in "self-defense."

Why do many kinds of mass hysteria seem to have need of a scapegoat?

When people feel a sense of guilt, they experience fear and hate directed toward themselves. A scapegoat is a figure who represents the sins of the community itself. Scapegoating permits the group to project its fear and hate onto an external object, to whom the actual sins or sinful wishes of the group are attributed, and thus relieves guilt feelings.

How is mass hysteria used in politics?

Demagogues characteristically attempt to achieve and maintain political power, and to direct the popular energies, by arousing mass hysteria. The techniques generally involve mass meetings, impassioned and prolonged oratory, and effective use of lighting, music, and emotionally provocative symbols. Responsible democratic political leaders may also use such techniques, but generally refrain from dependence on them, preferring to appeal to reason and to enlightened self-interest.

Do sudden religious conversions during revival meetings depend on mass hysteria?

Yes; but generally the experienced revivalist makes an effort to follow up the "hysterical" conversion with a more rational person-to-person approach. John Wesley, for instance, urged new converts to join small study groups where the commitments made during religious enthusiasm could be studied, appreciated, and fully accepted in the calmer circumstances of the days following the mass meeting.

Must mass hysteria be a highly emotional moment or is it possible for it to seep into individuals as a result of propaganda assimilated over a long period of time?

Mass hysteria is by definition both transient and highly emotional. But long exposure to propaganda can prepare a population for mass hysteria by establishing a favorable inclination toward the circumstances conducive to mass hysteria and toward the suggestions which will be made later.

Is there any connection between mass media and mass hysteria?

The mere fact that many people at the same time experience the same emotion, even an intense emotion, and undertake some action, in response to a communication via mass media, does not in itself justify describing the result as the working of mass hysteria.

The flight reaction to Orson Welles's radio production of *The Invasion from Mars* in 1938 is sometimes described as an example of mass hysteria; but it should more properly be regarded as a mass response to misinformation. Mass media are probably more effective in communicating the propaganda preparation for mass hysteria than in actually precipitating hysteria itself, because the target individuals are widely scattered and frequently alone or in small groups when they are receiving communications via the mass media. But mass media could

certainly prompt popular actions which would result in the condition favoring mass hysteria, for instance, by causing people to flee an area in such large numbers that escape panic develops.

Is wild adulation (for an entertainer) that involves screaming and clothes-tearing an example of mass hysteria? Is rock-and-roll dancing an example?

Mass hysterias certainly can develop in audiences responding to a popular entertainer. Rock-and-roll dancing in itself is hardly mass hysteria, even though audiences at rock-and-roll sessions have become hysterical. Mass hysterias have also occurred among audiences at other sorts of musical occasions and at sports contests.

Can mass hysteria have any good effects?

Yes. The religious rituals performed by various cults sometimes induce trance, dissociation of personality, or more or less wanton and uninhibited behavior. These hysterical activities, however undesirable they may seem to the outsider, may have a beneficial effect in reducing tension in the group by providing emotional catharsis for the participants. The participant, in other words, "works out" his suppressed feelings in a socially acceptable way.

MEMORY

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What is memory?

Memory is the capacity of living organisms to retain over a period of time some record of impressions, such as sensory experiences, thoughts, feelings, emotions, and muscular acts, which have been experienced at an earlier date. At its most elementary level, memory is manifested in the process of learning, by which impressions become registered in the brain and form the basis for a relatively permanent modification of behavior. The process of recall, which involves the reinstatement of registered material into consciousness at will, represents one of the most complex manifestations of memory.

What are the functions of memory?

Without memory, man would be no wiser than a vegetable. Each succeeding experience in life would be strange and unique. We should be unable to recognize people, objects, or even ourselves. There would be no recourse to language, manipulative skills, judgment, or any other aspect of intelligent behavior.

Where are memories stored?

Memories are stored in the brain. Localization of the memory trace or *engram* (the physical record of an impression) within the brain is not fully understood, but recent evidence suggests that the temporal lobes of the cerebral cortex may be an essential part of the storage system in man. This evidence is twofold. First, the remarkable work of Wilder Penfield, a neurosurgeon, has shown that mild electrical stimulation of the temporal lobes evokes trains of memories in humans, a phenomenon that cannot be obtained from any other part of the surface of the brain. Second, individuals suffering damage to the region of the temporal cortex display a severe and irreparable memory loss. (See *Brain Damage*)

In what form are memories stored?

No one really knows. Presumably, an impression sets up nerve impulses within specific parts of the brain, which in turn leave in their wake some structural modification of the neural tissue involved. This structural modification constitutes the engram. Arousal of the engram by nerve impulses resulting either from the re-experiencing of the original impressions or from the activity of engrams with which it is associated accounts for the phenomena of recognition and recall. The physical nature of the engram, however, has eluded investigators up to the present time. (See *The Nervous System and Behavior*)

Are memories stored from the moment of birth?

It is not improbable that they are. The fact that a person may not be able to recall experiences dating back to the first year of his life does not mean that storage of engrams failed to take place. The use of special methods, such as hypnosis and drugs, may result in the elicitation of memories of a very early origin. Psychoanalysts declare that the method of free association (unselected verbalization of whatever comes to mind) can likewise produce recall of very early childhood experiences. Recall of presumably "unstored" material can also be obtained in a state of hypermnesia (abnormal or extreme retentiveness of memory) brought about by a strong emotional shock, as in a moment of danger, while being anesthetized, or in a state of delirium. This evidence has led some investigators to agree with the statement that William James made many years ago: "Nothing we ever do is, in strict scientific literalness, wiped out."

Are memories stored in chronological order?

This is one of the fundamental attributes of memory in humans. Evidence for the chronology of memories is found in certain amnesia cases where all events within a circumscribed period of time are forgotten. Subsequent recall, if it does occur, progresses chronologically from the older to the more recent memories. Incidental evidence is found in the ability of almost everyone to rank virtually any remembered personal event as occurring either before or after another remembered event.

How far back into one's childhood is it possible to remember?

Under normal conditions of recall, the average person is able to re-instate material which goes back to the third and fourth years of life.

A few individuals, however, can recall experiences dating back to the first year.

Do women remember earlier experiences than men?

Virtually all of the studies concerned with this question have shown that adult women, on the average, recall experiences of an earlier origin than do adult men. In a study by George Dudycha involving several hundred college students, the earliest memories reinstated by women averaged out to be three years and six months. This compares with an average of three years and eight months achieved by men. This finding coincides with the established pattern that the nervous system of girls tends to develop more rapidly than that of boys, as evidenced in the earlier manifestations of walking, talking, and toilet training.

Does the nature of the event that takes place affect the date of our earliest memories?

Most early memories do involve vivid experiences of an emotional type, such as joy, fear, anger, curiosity, and pain.

Does the ability to remember have any relation to intelligence?

Other things being equal, the earliest memories that can be recalled, the length of memory span (immediate memory), and the retention of formalized learned material are all related to intelligence.

What is photographic memory?

This term is applied to any person with an exceptional ability to report from memory detailed information of visual material as though he could still see it. This accomplishment is mediated by "eidetic images," which are unusually vivid and relatively accurate images (memories, fantasies, or dreams) having a duration of several minutes. A typical test of eidetic imagery involves presentation of a picture containing numerous objects. After a brief inspection period, the individual with the ability for eidetic imagery can, by fixing his attention on a dark screen, visualize the picture at will and enumerate in detail the contents of the original.

Photographic memory is more loosely applied to any individual who has an extraordinary power to reinstate intricate material. One such example would be a "lightning calculator" who can report the logarithm to seven decimal places of any number ranging from one to one hundred.

Does a photographic memory indicate high intelligence?

Eidetic imagery occurs most often in children, under the age of fourteen years, who are of average intelligence. The rare adult who may have this ability need not be of high intelligence.

Almost any person may acquire the skill of an exceptional memory for a certain class of information through interest, time, and persistence. Even feeble-minded persons can develop an extraordinary memory. There is one case of a mentally retarded youth who could quickly and accurately report the day of the week of any date falling between A.D. 1000 and A.D. 2000. Another feeble-minded adult has demonstrated the ability to give detailed bibliographic information on a host of famous personalities.

What is the phenomenon that makes us feel we have experienced a new situation before, although we have not?

This phenomenon, sometimes called paramnesia or *déjà vu* ("already seen"), is not an uncommon experience in normal persons. On a long driving trip, for example, we may come to a strange town and suddenly seem to recognize it as being strikingly familiar despite the fact that we have never traveled through this area before.

Explanation of this feeling of familiarity is that the memory of the supposedly new experience is actually a memory of an earlier experience of a different sort that has since been repressed or forgotten. This earlier memory that is excited by the new experience is too weak to permit the recall of specific details and simply causes a feeling of familiarity.

Can one's memory be improved through special courses?

Strictly speaking, the capacity of memory cannot be altered to any great extent, but the efficiency of memory can indeed be improved. The major principle behind any special memory course is improved learning of the material to be recalled at a later date. For example, particular emphasis is placed on repetition of the learned material, organization of the material to be learned, and heightening the desire to learn the material. (See *Learning and Reading*)

How is it that words set to music and learned as songs are more easily remembered than words without music?

A familiar context, such as a melody, has priority in memory because it is organized on some logical basis and is greatly strengthened by rep-

etition. Learning complicated material against a background of poetic rhythm utilizes the same principle. Perhaps most of us remember the number of days in each month by the verse:

Thirty days has September,
 April, June, and November.
 All the rest have thirty-one,
 Except February alone,
 Which has twenty-eight,
 And on leap year has twenty-nine.

Without the poetic context, remembering this would be considerably more difficult.

Does mankind have a cumulative memory of its own history?

The phenomenon of *déjà vu*, the bizarre nature of dreams, and the apparent universality of symbolism in myths and religions have led some persons to theorize that part of the content of the unconscious mind is a product of biological inheritance (race memory). For example, Carl Jung and to some extent Sigmund Freud believed that a portion of the material in dreams is a remnant of the mental life of our ancestors. Many authorities feel that this theory has little or no basis in fact, either with respect to the inheritance of acquired characteristics or with respect to the analysis of dream content.

Do a child and an adult remember in the same way?

The processes of memory manifesting themselves in learning, recognition, and recall develop gradually with age. Three stages of the memory process have been identified by psychologists. In the first stage, which occurs shortly after birth and lasts up to the first year of life, memory is characterized mainly by the modification of behavior through repeated experience with certain situations. But these manifestations of memory are restricted to the immediate present and do not involve recall of past occurrences. In other words, the very young child has acquired knowledge from the past but is unable to view it as being part of the past. In the second stage, which may last up to the fifth year, recall of past experiences does occur but it is largely of the reintegrative type. Thus, on being asked to find a particular toy, the child may make his way to the place where he left it several minutes ago. Yet, there is an inability to give a point in time (yesterday, several weeks, months, or years) to his recalled experiences. The final stage of memory develop-

ment occurs at about school age when the child can reinstate material and at the same time refer it to some period in his own personal history.

Do lower animals remember in the same way that humans do?

Virtually all animals on the phylogenetic (pertaining to the evolution of a race of organisms) scale exhibit evidence of the first stage of memory development involving the modification of behavior (learning). There is also abundant evidence that mammals, in particular, have a reintegrative memory operating in the same way that it does in children. The third stage of memory, which involves recall of previous material from a definite period of the past, appears to be the exclusive function of the human brain.

Do thinking machines "remember" in the same way that the human mind does?

Electronic brains exhibit the properties of the first and second stages of memory. The processes involved, however, are quite different. While the human mind is fluid and reconstructive in its capacity to recall, the electronic brain is static and reduplicative. For example, the human reinstates the past in terms of his personality needs at the time of recall, which could make for erroneous memory. The thinking machine, in contrast, "recalls" experiences that are the exact duplicates of the original impressions.

What processes are involved in conscious recall?

Conscious recall depends upon the fact that impressions, as they are laid down in the brain, become linked or associated with other memories. By virtue of these associations, the arousal of a particular memory will tend to bring to mind other memories with which it has been associated. To recall anything, therefore, we must attempt to arouse other memories which, by their associations, provide a bridge to the memory in question.

What processes are involved in unconscious recall?

The same mechanisms as those involved in conscious recall are at work, except that they do not proceed at the level of awareness.

Unconscious recall is manifested particularly in dreams and in free association, but does occasionally occur in everyday waking activity when memories seem to come out of nowhere.

How does something from the past just "pop into the mind"?

This is an example of unconscious recall. Many of the impressions that we experience in daily life do not register in consciousness, although we may be able to recall them at a later date. Such impressions, of which we are unaware, may, by association, arouse earlier memories, which thus appear to pop into the mind without cause.

This phenomenon also accounts for the experience of two people recalling the same thing at the same time. Each is reacting to a particular impression, whether consciously or unconsciously perceived, with the same association.

How do smell, touch, or other sensory experiences evoke memories?

Memories are laid down in unified experiences. For example, a visit to a garden will establish individual engrams of odor, color, sound, and touch. At the same time, each engram becomes associated with succeeding ones to form an organized train of memories. The subsequent presentation of any one of these impressions can, by association, arouse the entire sequence of events.

How does free association of words cause significantly related memories to occur?

Frequently, conscious effort to recall a fact will fail, not because the memory is weak, but because of a prevailing emotion or some other condition temporarily inhibiting recall. Free association of words or thoughts, which involves a minimum of conscious guidance, taps the process of unconscious recall, which is not subject to such interferences.

How can memories be used to relieve emotional difficulties?

Many experiences, especially in childhood, leave memories that later are not subject to recall but that influence behavior. These memories constitute what clinicians call the "unconscious" and they may condition a person to react in peculiar ways later in life. Phobias or morbid fears are examples of such reactions. There is the case of a young woman who went to a clinic for psychiatric treatment. She complained of being deathly afraid of the sound of bells and burst into tears whenever she heard this sound. She was unaware of the cause of her condition. Special psychiatric techniques uncovered the fact that when she was five years old, she had witnessed the death of her mother under

very unusual circumstances and at the same time the bells of a nearby church began to ring. After the arousal of this memory, treatment of the patient's phobia was simplified. (See *Phobia*)

What techniques are used to help patients recall forgotten memories?

Psychiatric techniques include free association, drugs, and hypnosis. Free association may uncover significant material because of the lessened effects of conscious processes. Hypnosis and drugs are especially useful in cases where the patient is either unwilling or unable to recall significant material in the course of free association.

Do we tend to remember only what we want to?

We all tend to put out of consciousness those things that are distressing to us. In the individual, two mechanisms operate to do this. At the conscious level, we may *suppress* an unpleasant memory. That is to say, we deliberately turn our attention to other thoughts, and willfully avoid circumstances that will provoke the unpleasant memory; yet the memory may persist for days or even for years. At the unconscious level, there may be *repression*, which is the elimination from the consciousness of the recognition of those memories that cause unpleasant emotions, especially guilt and loss of self-regard. The main difference between suppression and repression is that the latter process produces a relatively complete amnesia for the events in question.

What are the dangers or difficulties that may arise when memories are repressed?

At least three dangers may be involved when a person attempts to deny the existence of certain memories. First, the effects of repression have a tendency to spread. In the young woman who was deathly afraid of bells, her fear at the height of her psychological condition had generalized to the sound of automobile horns and even to the tinkling of silverware. The second danger is that the process of repression requires the expenditure of "psychic energy" to maintain the material at the level of unconscious. This can rob the individual of energy needed to contend with everyday emotional conflicts. As a result, the natural processes of psychological development are retarded. Finally, repression may fail, and as a consequence, various neurotic or psychotic symptoms may appear in an effort to keep the material from being recognized.

Do we remember more happy experiences than distressing ones?

Numerous studies have shown that we do, and others have shown that we do not. But it must be kept in mind that both pleasant and unpleasant memories are remembered better than indifferent ones.

In experiencing happy memories, can we feel the happiness again? Can we feel the distress after recalling distressing memories?

All memories of a personal nature are associated with some pleasant or unpleasant emotion. It is a common experience that the evocation of a happy memory may produce laughter, and an unpleasant memory may cause blushing, long after the original experiences have taken place.

Can one experience remembered pain?

Fortunately, under normal circumstances, it is not possible to experience remembered pain. (See *Pain*)

Why does it seem that older persons are able to recall the distant past more readily than the recent past?

The difference is due, in large part, to their negative attitude and interest toward the present. Older people tend to feel more dependent, less energetic, and useless. The distant past, in contrast, allows the individual to recapture his youth, which is associated with pleasant memories of an active and useful life. The fact that the brain of an older person undergoes physiological changes which reduce its capacity to form new engrams is still another factor responsible for the preoccupation of the aged with the distant past. (See *The Aging and the Aged*)

Why are we inclined to color past experiences with a rosy quality that the event itself may not have had?

We do this in order to preserve our self-respect, which may be threatened by embarrassing memories. By distorting the memories of distressing experiences and aligning them with our personality needs, we make them more palatable to ourselves. Although we may at first recognize the distorted memories as being a subterfuge, repeated recall will gradually allow us to accept the distorted memories as being real.

Does the repeated use of a memory cause it to be more firmly fixed in the mind?

This is one of the fundamental means by which a memory can remain fresh, vivid, and subject to ready recall.

Does one automatically pull away from fire because the mind "remembers" being burned?

The reaction of withdrawing the hand from a fire before being burned is a type of learned response called a "conditioned reflex." The curious child who reaches for a flame soon associates the appearance of the flame with the painful reaction. The execution of this learned reflex in early life is made at the conscious level; thus the child can be described as withdrawing his hand because he remembers being burned previously. With repetition of this reaction through the years, the response does become automatic, that is, it does not depend upon the immediate awareness of the situation.

Other conditioned reactions that take on the character of being automatic are eye-blinking at the sight of an approaching object, typing, and pressing the brake pedal of a car when confronted with immediate danger.

What causes something to slip the mind?

The immediate cause is a temporary disconnection between a cue to a particular memory and the specific memory. This can occur as a result of a strong emotion (stage fright), disorganization of the memory process, and an overlay of previous memories.

To some extent, the process of remembering can be likened to that of muscle action. Just as the muscles of the body must be "warmed up" before we attempt to perform a task requiring a great deal of strength, the memory process must also be warmed up. At a moment's notice, we might be able to recall only little about our activities in grade school. With persistent effort, however, more and more details come to mind, including those memories that we thought were completely forgotten.

Can memories be "washed" away? Or replaced by new fictitious ones?

It is extremely difficult to "wash" away long-standing memories, but they can be replaced by new ones, whether the new ones are fictitious or not. It involves the process of associating a new set of memories with a given situation such that the future presentation of that situation will call forth these new memories.

How is brainwashing accomplished?

It is accomplished by the breaking down of a person's resistance to maintaining a given set of memories. This breakdown can be obtained

by overstimulation, severe conflict, or physical debilitation. During the time that his resistance is lowered and his judgment temporarily impaired, a person is highly suggestible and will accept alien ideas that would normally not be accepted. (See *Brainwashing*)

Are there any treatments for the mentally ill that could affect memory?

Convulsive shock therapy is known to produce a degree of retrograde amnesia (loss of recently acquired memories). Repeated convulsive treatments may extend the amnesia farther into the past.

How is it possible for a person to lose his memory?

An example of one of the most striking types of amnesia is the person who loses his identity. This is frequently called a "fugue" state. The person forgets his name, occupation, address, and is unable to recognize his family. Memory of impersonal facts may be intact. This kind of amnesia is almost invariably brought on by psychological factors, such as a strong emotional shock amounting to a crisis in the person's life. It is a means used by the individual to escape from, or to resolve, the crisis. For example, the soldier in the front lines is in conflict between remaining at his dangerous post as a duty to his country and fleeing from the threatening situation. He may suddenly lose his identity, run to the rear, and show people his identity card, which carries a name that he does not recognize. This person may have genuinely lost his identity, yet he also is in the process of trying to escape from the danger of the front lines. (See *Mental Mechanisms*)

How does a blow on the head cause memory loss?

Concussive traumas usually produce a loss of recently acquired memories only (retrograde amnesia), but the heavier the blow is, the more will the amnesia extend into the past. This memory loss occurs because newly formed engrams require a certain period of time to become fixed or consolidated in the brain. Engrams that have not had sufficient time to be consolidated are obliterated by a blow on the head.

Can emotional experiences cause loss of memory?

Strong emotional episodes may precipitate an amnesia for the events surrounding and including the emotional experience. A typical example would be a soldier who witnessed the death of his buddy on the battlefield. There may follow a complete loss of memory of the entire experience.

How is the memory recaptured?

Recovery of the memory may occur when significant details associated with the emotional experience are presented to the patient, or when the patient revisits the scene of the precipitating episode. If the lost memory is not revived, either hypnosis or drugs may be used.

Is it possible to forget whole blocks of experience?

The clinical literature contains cases of individuals who lost as much as three years out of their personal history. This condition is usually caused by brain damage.

What aids memorization?

Memorization is based mainly upon associating one idea, word, or concept with another through repetition and nearness in time. Memorization is facilitated and retention best aided by organizing the material to be learned into meaningful wholes. For example, the number, 3927812437292187, may be quite difficult to memorize in ten seconds and then repeat accurately one week later. If, however, one remembers that this number consists of multiples of three ($3 \times 3 = 9$; $3 \times 9 = 27$; $3 \times 27 = 81$; etc.), memorization and retention become easy.

Is it harder to memorize as one gets older?

When a person reaches the sixty to eighty age mark, his ability to memorize declines considerably.

How can the mind remember things it does not consciously hear, as repetitive learning while asleep?

Although a great deal of work has been done in this area, the results do not warrant any dogmatic statements as to whether engrams can actually be established during sleep. Suffice it to say, the amount of learning that does occur in sleep is so slight that it would be impractical to purchase records and equipment solely for the purpose of taking advantage of this phenomenon.

How does a dream gain access to the memory?

Recent studies have shown that dreams are most readily recalled when a person awakens within three minutes after experiencing the dream. A time lapse as short as ten minutes may produce complete

amnesia for the dream. This indicates that a dream is made up of impressions which do produce engrams, but which fade rapidly with time. Recollection of dreams otherwise forgotten occurs most often when a situation in waking activity bears some similarity to the dream content and is reinstated by association. (See *Dreams*)

MENARCHE

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What is menarche?

Menarche is the appearance of the first menstrual period. It occurs at puberty, a stage in the development of the female between childhood and full maturity.

Do all women menstruate?

The greater percentage of women do menstruate; it is rare for a young woman not to menstruate at all. The absence of menstruation is termed amenorrhea. If this condition continues beyond the usual age of onset of menarche, examination and study may reveal disturbances in the glands that secrete the hormones, which stimulate the onset of menstruation. Amenorrhea may also be due to nervous disorders, to congenital defects in the pelvic organs, to poor health and nutrition.

When no physical cause is found, most physicians today will consider the possibility of psychogenic amenorrhea.

What is the age range during which menarche usually occurs?

The range has been found to be between nine and seventeen years of age. It is said to vary according to differential effects of climate, heredity, race, diet, glands, and psychogenic factors. Much of the information about the onset of menstruation is based on reports from memory of women asked about it. Data based on direct observation show variations to be of much smaller range from 12.9 to 13.1 years of age.

What emotional and physical changes precede menarche?

Preceding the onset of menarche, and following her tenth year of life, a girl begins to develop physically at a faster rate than before. The secondary sex characteristics appear resulting in many changes, general and local. There is development of the body with rounding of the contour, enlargement of the breasts, growth of hair under the arms and in the pubic area.

It is now known that sexual, emotional, and personality development is a gradual process, and the attitudes and feelings of the child will influence all future developments. When development is healthy there need be no untoward emotional reactions to menarche and to puberty and its changes, but rather a continuing healthy one. There can then be anticipated an acceptance of her sexual and reproductive role.

The young girl will begin to relinquish some of her dreams and romantic views of the world and to develop a sense of reality. She will begin to abandon her dependent relation to her parents in favor of an independent one. She becomes absorbed in herself, in her body, in her developing sex characteristics. She is curious about and interested in sex, pregnancy, childbirth, and all its complications. Slowly she becomes aware of boys as being sexually different from herself.

What are a child's emotional reactions to menstruation? Do personality changes accompany menstruation?

It may be surprising to mothers and grandmothers that there need be no unpleasant or difficult reaction when menstruation occurs. It was difficult for them and they expect their daughters and granddaughters to experience it in the same way.

When menstruation was called "the curse" or "being unwell," it was not surprising that young girls did not look forward to it and found it distressing—at times even horrible and shocking. When a mother, without any explanation, slapped her daughter's face for summoning up courage to tell her about the bleeding (this is supposed to be done to bring color to pale cheeks), when the child's concept of bleeding was something that resulted from injury, it was not surprising that menstruation could be a period of anxiety and dread, of sickness and pain, and that the fears and anxieties would affect her role of woman, wife, and mother.

But today, as a result of increased knowledge imparted to the young girl at home, in schools, and through other agencies, one sees young girls welcoming the changes in their bodies, not hiding or feeling ashamed about them. They welcome menstruation as a sign of growth, happy to share this knowledge with their friends, proud that they too now have "it."

The personality changes begun in the prepubertal period continue.

What is the child's attitude at the onset of menstruation toward herself, her parents, her friends, her relatives?

With adequate preparation for this time of life—sufficient knowledge about sex and reproduction, reassurance and understanding of its

normalcy and significance, and knowledge of the specific details of hygiene and care of herself—the attitude of the young girl to the onset of menstruation can be completely accepting. She may even become proud of it as a sign of development and growth and of becoming a woman.

A sense of self develops. The young girl is increasingly seeking independence from her parents. Her struggle to attain it and relinquish her early dependence on them, makes her at times repudiate her parents in her effort to free herself. She resents their values and standards. She may then become more desirous of contact with the parents of her friends, with relatives, with teachers, and with other older people she meets.

If she is to be independent and her parents accept this, then they also expect her to assume the responsibility for her behavior. While at the same time, being concerned about her, they may inhibit and control her. The young girl may at certain times, wish to be dependent once more and thus cause some confusion to herself and to her parents. At times she may feel, and be, misunderstood by them.

She now desires not only to be loved but also to love, and may develop many infatuations and crushes on friends and on older women. These relationships may be salutary or cause grief if not reciprocated.

Having identified herself with her mother, she accepts, yet at times is frustrated by, her mother's behavior.

All this is predicated on a healthy development, but the vicissitudes of early development are many and these can result in extra problems and possibly even in sickness and personality disturbances. For example, an oversolicitous mother may keep her young daughter completely dependent on her. With menstruation considered a sickness, the young girl may use it to get attention, and the sickness may increase. If menstruation is considered unclean and dangerous, there will be anxiety, fear, and guilt along with it. Menstruation may serve as the stimulus to neurotic or even psychotic reactions as do other crucial emotional situations.

When can pregnancy first occur?

It had been assumed in the past that a pregnancy could occur as soon as menarche took place. The release of mature ova or eggs, however, is not regular, but occurs sporadically in the first few years of menstruation. There may be bleeding which is anovulatory (without ovulation). Anovulatory menstruation occurs in adult women too, but less frequently. If there are ova, pregnancy can occur at menarche;

with no ova, it is not possible. The term "adolescent sterility" is used to indicate the result of these anovulatory menstrual periods.

What are the reasons for a delayed menarche?

Many factors influence the beginning of menstruation. Heredity is believed to be one factor, transmitting a tendency to delayed menarche. Environmental factors, such as climate, nutrition, and the general state of health may cause some young women to menstruate late. Diseases of the endocrine glands, neurological conditions, and developmental abnormalities of the pelvic organs are other causes.

There is increasing evidence that emotional factors are influential in delaying menarche through their effect on the neurological and endocrinological systems. Overt traumatic experiences (which occur more often than is admitted) ranging from exposure of older men to actual contact with their sex organs, contact with the young girl's sex organs up to rape, can delay the onset. Conscious fantasies, frequent in the young, as well as unconscious ones, may also be an influence in the delay of menstruation.

Fear of injury to the sex organs as a punishment for childhood sex attitudes and behavior, especially masturbation, rejection of femininity with anxiety, fears, and hostility are among the unconscious feelings that will delay menstruation and also cause varying periods of psychological amenorrhea after its onset.

Are treatments available for overcoming delayed menarche or for difficulties arising from menarche?

The treatment of delayed menarche depends upon diagnosis of the cause. After a general examination, it is essential to inspect and examine the pelvic organs and perform the necessary endocrinological tests. In the past, treatment was not possible because parents would not permit their young girls to be examined pelvically fearing injury to the hymen, thus destroying evidence of their virginity. Also some mothers believed that such phenomena were natural and in any case it was wrong to tamper with nature. But today more and more mothers are bringing their children to doctors for diagnosis and treatment.

In most instances there is no need for treatment because amenorrhea in itself is not harmful or dangerous. To initiate ovulatory bleeding is still not satisfactory. As of today, there is no synthetic hormone or chemical that can definitely cause ovulatory bleeding. If, however, menstruation is delayed beyond the age of seventeen or eighteen, there

may be resulting irregularities later in life, or possibly difficulty in conceiving. In these cases treatment would be advisable. General health measures and treatment of organic causes are essential.

For psychogenic amenorrhea much can be done. Talking about one's fears to an objective and nonjudgmental person and receiving reassurance and sympathetic understanding can frequently allay and relieve conscious anxieties. Correction of misconceptions and added knowledge are of great help. However, at times, relief of unconscious conflicts requiring psychoanalytic therapy will be indicated.

MENOPAUSE

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What is the menopause?

Menopause is the cessation of menstruation—the end of the periodic cyclic bleeding that begins at puberty and continues through the reproductive years of a woman. It is evidence of the fact that a woman can no longer conceive and bear children.

The term *climacteric* designates the period of time during which menopause occurs, and is a more appropriate one than menopause.

The cessation of menstruation can be abrupt, but is usually gradual and occurs in various ways. The menstrual cycle may be prolonged or shortened. The menstrual flow may be increased in amount or decreased. The cycles may become irregular, with prolonged periods of no bleeding followed by regular or irregular bleeding.

All women have a menopause.

What is the age range during which the menopause usually occurs?

It is difficult to state any specific age at which a woman is expected to cease menstruating. There are wide age variations, but the menopause usually occurs from forty-five to fifty, with an average stated by some as forty-seven.

Are there physical and emotional changes that precede the onset of the menopause?

There are no physical or emotional changes that precede the onset of the menopause. Yet, if a woman has any physical or emotional problem around the age of thirty-five, it is frequently attributed to the menopause.

What physical changes occur during the menopause? After the menopause? Do any other changes occur during the menopause?

At the menopause, physically, the same organs that were affected when menarche occurred are involved when menstruation ends. The

ovaries do not respond to the hormones of the pituitary; the follicles and ova gradually atrophy, egg cells do not mature, there is no ovulation, no corpora lutea are formed, and the reproductive cycle is broken.

The symptoms that are attributed to menopause are many. The most discussed are hot flashes, sweats, headache, dizziness, palpitation, and exhaustion; and others are thickening and drying of skin, atrophy of the genital tract, hypochondriasis, suspicion, and depression; high blood pressure, arthritis, and rheumatism.

Some of the symptoms described are like those of anxiety states; they may remain undiagnosed and a neurosis may be completely ignored. Other symptoms are due to the aging process. Usually the emotional symptoms will occur in women with a previous history of neurosis or psychosis, or with a predisposition to emotional disturbances at crucial periods of their lives.

And some are symptoms of chronic conditions which occur when the menopause does and are erroneously attributed to it.

Most women do not have any symptoms at all. One woman with a delayed menstrual period asked her doctor whether she was pregnant. When it was determined that she was not pregnant, but probably beginning the menopause, she answered, "But I'm not nervous."

Again most women following the menopause feel free and at ease, not in the least disturbed by the menopause, but accept it as the end of reproduction, at a time when they do not want more children. But when the menopause is equated with aging they are distressed and unhappy, particularly in a culture that emphasizes youth, rather than maturity.

After the menopause is completed, do some women experience a reminiscent sensation at the time the menses would ordinarily have taken place?

No. Once it is completed, women do not experience any sensation at the time the menses would ordinarily have taken place. They are completely free of any subjective and objective evidence of menstruation.

Do women who have not borne children have a different or earlier menopause from women who have had pregnancies?

The menopause comes to single women, to women who are married but voluntarily or involuntarily childless, and to women with children in the same way. It may be emotionally charged for the childless because it means that any hope for ever having children is gone.

Because the menopause represents aging does it create unnecessary fears?

It is true, unfortunately, that the menopause does represent aging to many. In the past when women died in the forties and fifties and were old before their time, the menopause was considered part of the aging period. But today women live longer, so in most cases the menopause occurs many years before aging begins. But because it is still erroneously considered a sign of aging in a culture that adores youth, many women fear it. They fear that the menopause means the end of their lives as women. They fear that they will be nervous, upset, and depressed. They fear the loss of their youth, they fear that their sex lives will end, and at the same time they fear pregnancy at a period in their lives when they don't want children. They fear the loss of their husbands' love. They fear the loss of their prestige and influence; the woman with a job fears that she will lose it, and women at home fear that their children will no longer need them.

All these unnecessary fears bring with them other emotional reactions. But since most women do not have such symptoms, they can go on functioning well and happily during this period.

Is there a marked change in sexual desire after the menopause?

There is a persistent fear in many women (and in men, too) that brings a great deal of unhappiness to them, namely, that a woman's sexual functioning ends at the same time that her reproductive functions end. It is interesting that even medical books frequently mention a woman's "generative organs" in describing the pelvic structures. They imply that these organs are for procreation only and are not also organs of sexual function.

But, women are finding out that their sexual desires and satisfactions remain after the menopause. And in fact, in some women sexual desires develop after the menopause, merely because they are relieved of the fear of unwanted pregnancies.

It was assumed, because they didn't discuss it, that older women had no sex desires. One aging widow, many years past her menopause, when asked whether she and her women friends still had sexual desires, answered, "Sometimes it is difficult to fall asleep." And one woman of sixty-five in discussing women and sex with her doctor, particularly in relation to her young daughter, said of herself, "I still enjoy it. Isn't it a shame?"

It can now be definitely stated that if a woman has sexual desires, they will continue throughout her life. If she never had desire, it would be advisable to find out why she cannot now begin to enjoy it.

Why do some women begin to demand more affection from their husbands after the menopause?

Some women, and particularly men, do not manifest much affection in the later years of life, but are not distressed about it, because they feel it. But some women may need greater reassurance at the time when they fear the loss of their usefulness and attractiveness. They need to be assured that their husbands still love them now that their major job is over—that of conceiving, bearing, and rearing children. A woman is then more aware of, and has more time for, her relationship with her husband. She wants to have a greater share in this relationship, since all her emotional energies are now available for it.

Many men are pleased and respond to her need, but, unfortunately, in some instances the husband has been resentful of the wife's absorption in the children, or his interests are concerned primarily with his work, or he has lost interest in his wife sexually, or at times his affection has been given to another.

Can the menopause be brought on by an operation? What would be the necessity of such an operation?

Since the anatomical structures involved in menstruation are essentially the uterus and ovaries, benign and malignant tumors, or occasionally severe inflammation, may require removal of these structures with resulting cessation of menstruation and the inability to conceive.

In operating on women before the menopause, whenever possible, conservative surgeons always try to prevent an early, artificial menopause. For example, where the ovaries are affected in a young woman, if at all possible one ovary or a part of one is preserved to permit pregnancy and menstruation. Only in cases of malignant tumors, even in a younger woman, might the ovaries be removed to preserve her life. In a younger woman, only the tumor itself (of the uterus) would be removed, to preserve the uterus for pregnancies and to prevent the cessation of menstruation. However, in a woman in her middle or late forties who has had children, the uterus would be completely removed and sometimes even the ovaries, and an artificial menopause would be brought about. The menopause would occur a few years earlier than usual, but with no additional symptoms.

What is a hysterectomy? What are a woman's reactions to a hysterectomy?

A hysterectomy is the surgical removal of the uterus.

Women who are healthy emotionally would not want an operation unless absolutely necessary. They are the ones who will follow the advice of the physician when he advises surgery or when he suggests that the tumors should not be removed but checked regularly. More women will react favorably to having the uterus removed after they no longer expect to have children.

In a single woman one can expect a temporary, severe emotional reaction after a hysterectomy, because it ends her ability to conceive and to bear a child. This would also be true of the married, but not voluntary, infertile woman.

There are erroneous impressions regarding the results of the removal of the uterus. Women think there will be a cessation of sexual desire, "a drying up of their sex organs," and they fear the "dreaded" symptoms of the "change of life"—none of which occur. As long as the ovaries remain there will be no menstruation, but they will still be secreting hormones. Conception will not take place, but sex functioning continues since this does not depend on the presence or absence of the uterus or the ovaries.

Some women will fear a hysterectomy as a loss of their youth and womanliness. Some will retreat into inactivity for sympathy and dependence. Other conscious and unconscious motives wholly unrelated to this particular operation will play a part in reactions to a hysterectomy.

Is there a relationship between the menopause and any other physical illnesses?

It must first be restated that most women during the menopause are quite healthy, and have no symptoms.

Textbooks still state that there is a specific depression occurring at this time, called *involutional melancholia*, and also a form of arthritis called *menopausal arthritis*. Presumably it would be due to the decreasing hormonal production by the ovaries. But surveys now reveal and most authorities accept the fact that depression, when it occurs, is not due to a loss of hormone, but comes to women who in the past have already reacted to stressful periods with varying degrees of depression. Arthritis generally manifests itself in the years during which the menopause occurs.

The similarities of the so-called classical symptoms resemble those of anxiety states and again are not solely attributable to the menopause.

There are symptoms of sweating and flushing of the face and the rest of the body, usually minor and temporary, which women experience only at the time of the menopause. Occasionally they can be very distressing. There is no definite knowledge, however, as to why this particular effect on the vasomotor system occurs.

Many other conditions attributed to the menopause, and they are many and varied, are those which generally develop during the fourth and fifth decades of life; and there are others which are not due to biological or physiological causes, but to psychological, social, or economic causes.

Why do some women suffer from various emotional disturbances, while others do not?

To most women, the menopause is welcomed as the end of the reproductive cycle. But to those women who have never had children—because they were involuntarily childless—and to single women, it signals the end of their hopes. The woman who marries late in life is also one who reacts unfavorably. Recognizing that conceiving and bearing a child fills a great need in almost all women, it is not surprising to find an adverse emotional reaction in the groups of women mentioned above.

However, superstitions, ignorance, and fears have made this period one of dread for many women, and an increased time of anxiety and depression for seriously neurotic and psychotic women.

Most women do not, and more would not, experience any emotional disturbances had they been inculcated early in life with healthy attitudes.

What treatments are available for the relief of the emotional and physical changes of the menopause?

The physical symptoms that may occur at the time of the menopause, and are not attributable to the menopause, need diagnosis and treatment. Because most physical symptoms at this time are blamed on the menopause, many conditions may go undiagnosed and untreated. This is when a woman needs more frequent checkups; the yearly physical examinations should now be done every six months.

Physical symptoms of irregular or excessive bleeding need investigation and treatment. For the hot flashes and sweating, hormonal therapy, orally or by injection, may be very helpful.

For symptoms not due to the menopause, but to fears, taboos, ignorance, misinformation, cultural attitudes, and years of unhealthy experiences and feelings that affect some women at this time, much can be done. Reassurance, sympathy, and understanding help a woman in adjusting to herself, to her husband, and to her children who may now be on their own. A new role is now open to an increasing number of women who need just such a helpful interest.

But above all there must be preparation for this period—education for the development of emotionally healthy women who can find joy in accepting themselves as persons, as wives, as mothers, and as grandmothers.

Periodic emotional evaluations, physical checkups, and stocktaking of marriage are preventive measures in the treatment of the menopause.

What is the effect of these treatments?

Frequent and regular examinations and particularly cancer tests, increasingly accepted by women at this age, are diminishing the ravaging effects of cancer and other physical conditions.

Hormone therapy is a boon not only to the career woman who is distressed by the flushing and sweating, but also to the woman at home who is plagued by these same symptoms.

Reassurance, sympathy, and understanding, not indulgence and hostility to the complaints of a woman at the time of the menopause, help to make her accept it more readily.

Various communication media have been of great help to counteract the unreasonable fears of women during the menopause and to educate them to accept it with equanimity, and not to fear the loss of youth. Interestingly enough, retaining youth is also stressed by the same media.

Women are beginning to accept the fact that when they are middle-aged the phenomenon of menopause is nothing to be ashamed of. They read about it, and they listen to discussions about it. A recent television program on "change of life" was viewed by many millions and was well received by men, women, and critics alike.

Guidance and psychotherapy are being increasingly sought and have made for greater acceptance of, and ease of reaction to, the menopause.

Based on current research, what might be predicted about future attitudes and treatment regarding the menopause?

The little girl who thinks of the onset of menstruation as a sign of growth, looks forward to it, and welcomes it; the young woman who

can accept it, will be glad to be what she is—a person, a female, a woman; the woman who plans her pregnancy welcomes it and the delivery in a natural way; she who lives her life contentedly as wife and mother, will be the woman who at the menopause will accept the end of the reproductive cycle.

In the future, physicians will see less and less of the menstrual irregularities and pains, the complications of pregnancy, and the problems of the menopause. That there will be no treatment for the menopause as such, can be predicted. It will be a part of the normal, uncomplicated development of women.

MENSTRUATION AND THE SEXUAL CYCLE

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What is menstruation?

Menstruation is a periodic physiological bleeding occurring in women at approximately four-week intervals. Its source is the lining of the uterus (womb) called the *endometrium*. As a rule menstruation is preceded by ovulation (extrusion of an egg cell from the ovary) and changes in the endometrium.

The two ovaries store the eggs and also supply hormones. One of these hormones, *estrogen*, is responsible for the growth of the uterus and vagina and the development of the secondary sex characteristics. This hormone continues its effect throughout the reproductive cycle. The stimulus that starts the functioning of the ovaries at puberty comes from a small but powerful gland situated at the base of the brain called the pituitary gland. Among others it develops hormones called gonadotropins which directly stimulate the growth and function of the ovaries. The estrogenic hormones manufactured by the ovary initiate a cycle beginning with the thickening of the lining of the uterus. Then the estrogen is withdrawn, the blood vessels in the lining of the uterus break, and the blood together with the thickened lining are carried off through the lower end of the uterus into the vagina where it appears as menstrual bleeding. This type of bleeding is called anovulatory bleeding. It occurs at the menarche and on occasion throughout the life of a woman, and particularly when the process ends at menopause.

Usually, however, the pituitary gland sends out another hormone to the ovary, and as a result of this the ovary begins to extrude an egg (which is accomplished by bursting through the follicle that contained it). The egg moves into the Fallopian tube (oviduct) where it will wait for a sperm cell to fertilize it. At the place where the egg is extruded from the follicle, a yellow body called the *corpus luteum* is formed in the ovary. From this, another hormone, *progesterone*, is de-

veloped. Under its influence the lining of the uterus thickens more and becomes ready to receive, protect, and nourish the egg should it be fertilized. If conception does not occur, there is a breakdown of the blood vessels and the lining of the uterus, and ovulatory menstruation results. The cycle then begins again.

The first day of menstruation is designated as the first day of the menstrual and sexual cycle.

Does a woman's attitude toward menstruation reflect her feelings about sexuality, motherhood, and femininity? How?

As a periodic reminder of her role as a woman in relation to her sex and reproductive function, a woman's attitude toward menstruation has great significance and impact.

A healthy accepting attitude begun early in childhood and continued throughout a woman's development brings menstruation regularly without premenstrual tension and without pain. She will welcome the first signs of pregnancy—a delayed menstrual period; she welcomes its reappearance after pregnancy, and does not permit it to incapacitate her; and when her reproductive life is over, she accepts its end.

But the first sign of a serious emotional disturbance may be a cessation of menstruation, and its reestablishment, a sign of recovery.

It is obvious that this can occur because there is a direct nervous connection between the pituitary gland—the initiator of the menstrual cycle—and the hypothalamus, which is involved with the bodily manifestations of the emotions. The autonomic nervous system also affects the reproductive organs and is itself affected by the emotions, causing dysfunctions and tensions.

Fears of being a woman and rejection of this role, fear of sex, and fear of pregnancy (either conscious or unconscious) are at the base of many of the disturbances of menstruation.

As the symbol of womanhood, sex, and reproduction, a woman may be annoyed by the discomfort that comes with menstruation and be terrified by any delay because it might mean pregnancy. She may have anxiety, irritability, and some physical discomfort premenstrually, varying degrees of pain and discomfort during the bleeding period, irregularities of the cycle, and in some instances depression.

At times fears and anxieties regarding her sexuality, motherhood, and femininity may be causal or add to difficulties in conception through hormonal or nervous tension reactions. During pregnancy

these women may develop physical and emotional complications. Labor may become prolonged or difficult; and finally a woman may be led consciously or unconsciously to reject the child she presumably wanted, planned for, and gave birth to.

Many women are seen in doctors' offices, fearful and anxious about a delayed period. They fear pregnancy, either because they are unmarried or, if married, are not physically or emotionally ready for it. Frequently, the next day or a few days after, they menstruate. In these cases reassurances of the doctor and his acceptance of their attitude is capable of bringing on the menstrual period.

What can cause irregularity of intervals between the menses? Why in some women can the interval continue for months or years?

Oligomenorrhea is the term used to designate irregularities of menstrual cycles in terms of intervals between bleeding periods. It is a reduction in the frequency of menstruation, the intervals varying from thirty-eight days to three months.

The physical causes are many and similar to those causing periods of *amenorrhea*: diseases of the pelvic organs, acute infections, chronic infections and diseases, and mental and emotional disorders. The intervals continue depending upon the particular nature of the physical condition. Correction of these conditions should be by medical or surgical means.

In psychological or emotional oligomenorrhea the degree of the psychopathology—the conscious or unconscious resistance to giving up and the desire to hold on to the emotional conflicts—will be a factor in determining how long the condition will persist and how amenable it is to treatment. Most women will accept the condition when reassured that the physical structures are normal; others continually seek the doctor's help when the irregularity occurs and persists.

Irregular irregularity is much more troublesome to women than is a regular irregularity, which they can become quite used to.

What is the menstrual or sexual cycle?

The menstrual or sexual cycle is a periodic cycle that usually lasts twenty-eight days and occurs throughout the reproductive life of a woman. It is of interest to note that the reproductive function is the only one that ends during the lifetime of a woman.

The cycle is divided into three phases:

1. The estrogenic phase—during this time, from the end of the menstrual or bleeding phase to ovulation, the lining of the uterus is repaired and an ovum matures to a point where it can be extruded.
2. The progestational phase—during this time ovulation occurs and the uterus is further developed, prepared to receive the fertilized egg, and to nourish it.
3. The menstrual or bleeding phase—a period of bleeding which occurs when there is no fertilization of the ovum and during which time the extra blood vessels break, and the extra tissue lining is discarded, since it is not needed for that particular cycle.

Then the estrogenic phase begins again.

Does sexual desire increase during certain phases of the sexual cycle? At what times does this occur and what are the causes?

Most scientific observations regarding the relation of sex desire and the phases of the menstrual cycle have been made of animals. As a rule female animals will accept the male only at estrus (mating time). But according to Frank Beach, an expert in sex functioning in animals, "The dependence of sexual receptivity on gonadal hormones grows progressively weaker." This happens the higher one goes in the mammalian scale, and the sex desire becomes more dependent on the psyche. This is particularly true in the human being.

Therese F. Benedek and Boris B. Rubenstein, from studies of a number of neurotic women, conclude that there is a significant correlation between sex activity and the phase of ovarian activity in the sexual cycle. They found that there was increased sex desire before ovulation with a desire to be relieved of the tension. This reached its highest point at ovulation. After ovulation there was diminished sex tension and a more passive state.

But in the average population there are many women with sex desire only in relation to the menstrual period—before, during, and after, with no desire for the rest of the cycle. There are few who have any desire around ovulation time. Increasingly the young women of today, freed of cultural and emotional inhibitions, with healthy attitudes and adequate education, are showing greater frequency of desire, completely acyclic, i.e., with no relation to any part of the sexual cycle.

Are there any scientific guides concerning sexual intercourse during menstruation? Can it be physically or psychologically harmful?

There is still some adverse opinion about coitus during menstruation based on the fact that for centuries a woman was considered taboo during the menstrual period. The Bible prescribed seclusion for the menstruating woman and prohibited sex. Any fear of possible contamination of the male and harm to the female is a survival of primitive superstition, because menstrual blood is very "clean."

There may be aesthetic objection to coitus at this time but there is no evidence from actual experience that coitus is harmful during menstruation. If a man or a woman considers it unclean and harmful, he or she reacts angrily to the request for coitus at this time. (Each might also consider the spouse too highly sexed or abnormal.)

Yet many men and women do indulge in it. Certainly, if a woman's desire is intense at this time and her husband is willing, it is advisable to have coitus during this period. But if a woman finds it uncomfortable and unacceptable, her feeling should be considered.

Is it possible for conception to occur during the menses?

Based on the concept accepted by most physicians, biologists, and endocrinologists that ovulation occurs only once a month, and in the midmonth of the cycle, there should be no possibility of conception during the menses. Yet, occasionally physicians report that a patient, whom they consider to be reliable in observation and judgment, did have coitus only during the menstrual period and that conception did result.

There are physicians who believe it is possible to conceive during any day of the cycle. Experimentation is presently in progress to discover a more definite test of ovulation than the ones available at present. When one is found, there will be more knowledge to confirm or disprove the present-day concept that there is only one ovulation occurring in midmonth.

Does menstruation ever occur during pregnancy?

Occasionally menses continues for one to two months after conception takes place. This type of bleeding varies from the usual; the bleeding is scantier, and the cycle shorter. For the remainder of the pregnancy there is no bleeding. At times, because of the bleeding, a woman may be unaware of the fact that she is pregnant.

There need not be any concern to the woman in whom this occurs.

However when this type of bleeding does occur, it is desirable to investigate the cause.

How soon after childbirth does menstruation resume? Can conception take place before menstruation resumes?

After delivery of a child, menstruation reestablishes itself at varying times. If a woman does not nurse her infant, menstruation will appear within four to eight weeks. For the woman who nurses her child, the variations of time of resumption of menstruation are great. It may vary from two to eight months.

Conception can take place before menstruation returns in the few instances where there is ovulation without menstruation. Usually the ability to conceive again does not recur until after the first or second menstrual period.

Are there valid reasons for avoiding certain activities during menstruation, both sports and physical exertion?

When menstruation was considered a sickness, of necessity all forms of physical activity were prohibited. The woman who feels that menstruation is "the curse," and who has emotional conflicts about it as well as varying degrees of discomfort or actual pain, will not desire to be active during this time.

The mother who still believes that one can cause injury to "delicate organs" will prohibit her daughters from bathing and certainly considers any form of activity harmful.

Medical texts are still careful in their attitude toward this problem. But *Novak's Textbook of Gynecology* by Edmund R. Novak and Georgeanna S. Jones states, "While violent exercise is not to be advised, reasonable activities such as golf or even a leisurely game of tennis should not be harmful to the normally menstruating girl."

With the help of newer methods of hygiene, young women today can do everything during menstruation that they do at any other period. Not only do they bathe, but they also swim and participate in all kinds of games and sports. There has been no evidence of any harmful effects from these activities.

Are there mood changes during the sexual cycle? When are they likely to occur and why?

The evidence that mood changes occur is based on statements made by emotionally disturbed women. The study by Benedek and

Rubenstein already referred to, showed definite mood changes corresponding to the phases of the sexual cycle by correlating analytic findings and the phases of ovarian activity.

There is one phenomenon in the cycle, premenstrual tension, that occurs in an estimated 40 per cent of women. In addition to physical symptoms such as headache, breast enlargement, at times increased desire for food or fluids, weight gain, as well as swelling of eyes, feet, and ankles, there are emotional symptoms which vary from mild anxiety and irritability to crying spells, depression, and at times temporary but severe mental disorders. These will occur in women who otherwise seem perfectly well controlled. In the emotionally disturbed women the symptoms will be exaggerated. As a rule, this phenomenon occurs premenstrually two weeks, one week, or a few days before the flow; occasionally it occurs during or after it.

But because the greater number of women do not experience the phenomenon (and at times observation has shown that some women have increased well-being before menstruation), one can conclude that there are varying degrees of sensitivity in women to the complex physiological, hormonal, and psychological changes that occur.

With the menstrual and sexual cycle as complex as it is, it may cause surprise that the greater number of women are not emotionally affected by it. Preventive education and healthy attitudes will help greatly in increasing this number.

What are the various forms of menstrual disorders? Are there treatments for remedying them?

The various forms of menstrual disorders include:

1. *Amenorrhea*—no menstruation. This is primary when menses fail to appear initially, and secondary when there is cessation of menses after the initial menarche.
2. *Cryptomenorrhea*—bleeding occurs but does not appear externally due to developmental defects.
3. *Oligomenorrhea*—reduction in frequency of the menses.
4. *Hypomenorrhea*—reduction of the number of days, flow, or the amount of menstrual blood.
5. *Hypermenorrhea* or *menorrhagia*—abnormal increase of menstrual flow.
6. *Premenstrual tension*—psychosomatic symptoms occurring usually before menstruation.
7. *Dysmenorrhea*—painful menstruation.

The appearance of any of these necessitate a physical examination and endocrine or hormonal studies to determine the cause of the disorder. Treatment will depend on the cause, and remedies are available for most of them. When the cause or concomitant or resulting factors are psychogenic, psychotherapy is indicated.

Preventive therapy—education and inculcation of a healthy attitude toward the whole phenomenon of sex and reproduction—begun in childhood and continued throughout the life of a woman will help to eliminate completely the greater number of these disorders.

Why do some women feel pain during menstruation?

Questioned about her menstrual period, a young woman said to the doctor, "And I have the usual, natural cramps of menstruation." All the old notions that the menstrual period is a sign of sickness, of difficulty, of incapacitation have not as yet been completely expelled.

However, organic causes can bring pain at menstruation. There are certain tumors and pelvic inflammatory conditions which can cause varying degrees of pain. Intermenstrual pain found in some women, and evidence of ovulation, is rarely strong pain, usually dull and aching in character and lasts from a few hours to a day.

Most physicians agree today that pain during menstruation can be psychosomatic, others say that in the absence of organic causes it can be purely psychogenic in origin.

Treatment must be preceded by an examination to rule out organic causes, which can then be treated. The many hormones, sedatives, and analgesics that are increasingly used, demonstrate that there is no one specific solution to cure menstrual pain in all women. Some drugs relieve some women for a time. Psychotherapy to eliminate anxieties, fears, and guilt is a most effective means to cure the condition. Preventive therapy is the best answer to its elimination as a problem for women.

MENTAL DISORDERS, CLASSIFICATION OF

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What is a classification of mental disorders?

In simplest terms a classification of mental disorders is a sorting and storage system designed to arrange all individual cases of mental disorder into sections, subsections, and compartments reserved for them. Mental disorders only are permitted into this storage system and every such case can be put into a compartment proper for it. Each compartment contains only those cases that have the same designated characteristics and excludes all others. All compartments are grouped progressively into subsections and these again into sections arranged in a hierarchal order according to how closely they are related to each other. This arrangement is determined by the concepts or theories chosen to form the basis for this system of classification. Each container and grouping has labels that represent the names of the mental disorder in it. There may be more than one name on each label to designate that it contains cases that are alike in possessing the basic qualification for inclusion in this particular division but are different in some other qualities. These various "names" constitute the Nomenclature of Mental Disorders. A nomenclature can designate every individual mental disorder or group of disorders, while a classification is a system of grouping individual cases into classes according to criteria of similarity and difference which we conceive to be significant for this purpose. The concepts on which we establish these criteria for classifying mental disorders vary with the theories we have developed on the basis of our present knowledge, with what further knowledge we seek to acquire, with the specific uses we plan for the classification, etc. Different principles therefore may be employed to classify the mental disorders in different situations. For instance, the "International Statistical Classification of Diseases, Injuries, and Causes of Death" of the International Statistical Institute of London, first divides all Mental Disorders into *Psychoses, Neuroses, Personality Disorders, and Mental Deficiencies,*

while the official "American Standard Classification" divides them primarily into *Organic Brain Disorders* and the *Functional Mental Disorders*.

Why do we classify?

It is a human trait to differentiate and put into classes things we observe. As our thinking develops, and as we become acquainted with and start naming the things or phenomena around us, we start classifying them first mainly according to what effect they have on us. They are pleasant or unpleasant, dangerous or friendly, hot or cold, etc. We then may add some causal or associative relationships that have meaning for us to our criteria for classifying the phenomena around us; for example, things on our plate are to be eaten, "hot" things hurt when touched, etc. As our experience and knowledge increase, the differentiation of observed things into classes becomes more sophisticated and involves dividing the same things according to various conceived qualities or criteria—children may be boys or girls, smaller or bigger, friendly or mean, etc. We tend to order observed phenomena and things into a hierarchy of related classes. As our knowledge and thinking capacity increase our need for logical understanding, more conceptual principles or abstracted qualities are introduced to arrange phenomena in our mind. Our schemes of classification then approach being "scientific." On the one hand, a classification depends on how much we know of the phenomena we classify and reflects the theories we derived from this knowledge. On the other hand, a classification forms a foundation on which further knowledge can be built or developed. In classifying objects or phenomena according to their traits or characteristics, we work with conceptual principles and test the theories or "laws" we believe govern their relationships. In our study of the objects of our classification we seek to verify or modify the criteria and principles we have used in ordering them and to find clues for further knowledge of them, e.g., the classical example of Dmitri Mendeleev's table of chemical elements.

Our classification of mental disorders also serves the purpose of enabling us to pool our separate experiences for the common use of all who work with and study these phenomena. It serves to enhance our communication with each other, as well as our mutual understanding. To best achieve this we need to define the criteria by which we chose to classify the mental disorders so that they are understood and are applied as uniformly as possible by everyone. The descriptions of

our standards must be as unambiguous as possible and should depend on as many objectively measurable items as possible. This is, however, difficult in the area of mental phenomena not only because they are inherently unavailable to objective measurement, but also because of divergences in the conceptualization of the same theoretical principles by different psychiatrists. Even though we have made agreements with each other, for instance, in the United States, on some principles, criteria, and definitions for the purpose of classification, and published them in the American Psychiatric Association's *Diagnostic and Statistical Manual* on Mental Disorders, we still lack a desirable uniformity in "diagnosing" and classifying the patients we see. The statistical, epidemiologic, and ecologic data based on this classification are, therefore, less accurate and useful than one would wish.

Dealing with mental disorders involves judgments of many observed and deduced phenomena in the past, current, and future life of an individual whose mental reactions we study. The many factors that influenced him and the multiple variations in the details of his behavior make a classification of people with mental disorder difficult but especially necessary for a common understanding of these phenomena. A useful classification not only establishes an ordering of these factors according to their relative importance but also provides a basis for a common rational understanding of their relationship to each other.

What are "disorders"?

This involves a differentiation of illness from health and is complicated by the lack of clear demarcations between health and illness. While it often is quite apparent that a person is ill, it is at times difficult, or even impossible, to tell on the basis of our external observation of him whether he is "well" or "ill." When we see someone who can barely stand up and who is gasping for breath, with an expression of distress on his face, he may have a severe heart disease and may be seriously ill or may have just run a hundred-yard dash and be in "perfect health." His extreme effort to supply himself with oxygen may persist, without any significant physical activity, because of a severely damaged heart or may be a transient response to an unusually severe physical exertion from which he will soon recover. In order to establish that the first example represents an illness, and the second not, we must depend on knowledge of what preceded the same unusual behavior, what happens to it later, and perhaps on further tests. People may have a marked sensitivity to bites of spiders or bees or to the ingestion of

some food without manifesting it for years and are generally not regarded as being ill. When exposed to the particular noxious substance and actually reacting to this with disturbance in their functioning, they are considered ill. When their disturbance in functioning disappears, we regard them as having "recovered" their health even though their sensitivity remains. When a person has a locally weakened blood vessel wall and is likely to suffer a serious hemorrhage, he is certainly especially vulnerable to "illness" but he is not considered to be ill until a rupture has actually occurred. Many adults living in cities have small calcified lymph nodes visible in their chest X rays. These represent scars from earlier slight tuberculosis infections that are now "inactive." These people were never aware of any disturbance in health, have no current impairment of function, and are not "ill." Individuals may have structural conditions such as a mild heart valve damage, a malformation of a foot, a distortion of optic lenses, or a general bodily configuration that imposes limitations on their physical capabilities or makes them less tolerant of specific stresses. Here again we may describe their special physical status or "diagnose" it as a deformity, malformation, or somatic anomaly, but we generally do not call them ill unless there is an active disturbance in their usual equilibrium and a stressful struggle to reestablish it. The above examples, from the so-called structural or physical sphere, were cited to show that our distinctions between health and illness often have to be on the basis of rather arbitrarily chosen conceptual factors. In the area of mental functions people are likely to have individual idiosyncrasies. Their multiple differences in inborn endowments and developmental influences result in marked variations of individual methods of functioning, vulnerability to stress, and capabilities for overcoming a disturbed equilibrium. The "normal" variations in individual mental traits, characteristics, capacities, and vulnerabilities are quite great. The manifestations or symptoms observed in the mentally ill may not be distinguishable from reactions in "healthy" persons. The person who grieves over the sudden loss of a loved one is not much different in appearance from one who is "pathologically" depressed. The first will soon recover, the second may not have suffered an actual loss and may be incapacitated by his "disorder" for months. Some of us may have become sensitive to certain life situations to which we react with stress. These may be related to some failures or successes, restrictions or freedoms, changes in routine or lack of them, separations from people or intimate closeness with them, etc. When exposed to the situations

poorly tolerated by us, we may experience severe disruptions of functioning. The various mental faculties may vary considerably and the "structures" of the mental apparatus have different strengths or weaknesses. "Scars" from past stressful experiences may make us more susceptible to "illness" by limiting our capacities for dealing with current stresses. Generally these variations of individual patterns and effectiveness of reactions are not regarded as outside the limits of "health" unless some gross current dislocation of the usual "adjustment" occurs. However, when such vulnerabilities require us to exert effort to avoid or eliminate stresses with a limited repertoire of mental reactions, we may have a mental abnormality that needs to be classified as a Mental Disorder. Though currently not grossly disrupted, such mental states severely restrict the adaptability of the individual for whom they are characteristic. They are diagnosed as "mental disorders" only when they have manifested themselves in a prolonged or repeated failure of the individual to achieve the usually expected adjustment in his situation. The classes of Mental Deficiencies and the Personality Disorders represent such mental disorders. These are nearly lifelong mental conditions in contrast to the other groups of mental disorder which occur in people who had previously functioned satisfactorily.

The "mental disorders" as a class of all disorders of human functioning need to be separated from the other or "physical" failures of health. The mental and physical aspects of human functioning have however no distinct natural boundaries, so again we must make this distinction on the basis of our somewhat arbitrary concepts of what is "mental" and what is "physical." Here, too, there is no complete uniformity of concepts or of resultant classifications. We generally regard as "mental" all ideational and intellectual functions of the person, his subjectively perceived emotions, and his total behavior as an individual. This behavior embraces particularly those purposive or aim-directed activities, no matter whether they are rationally, emotionally, or impulsively determined, consciously or unawaredly performed, that are mediated through our brain. Our thoughts, feelings, and behavior, how we experience and respond to the various outer stimuli or inner urges depend on the integrity of our entire body, particularly the nervous system. The mind does not exist outside of the body and a living body does not exist without a "mind." The whole person is affected whenever either the mental or somatic aspect of his functioning is primarily disturbed or "disordered." Any illness affects to some extent both the psychic and somatic aspects of the individual. We say that he has a

"mental illness" when the disturbed functioning manifests itself predominantly in his mental activities or when his disorder primarily originated in, or was directly mediated by, some processes in his mental functioning.

A disorder of the body, particularly of the brain, can secondarily produce intellectual, emotional, or behavioral disturbances of sufficient degree that diagnoses of the disturbance in anatomic structures as well as of mental functioning are required. For instance, an acute inflammatory disease of the brain would be diagnosed as "encephalitis" and an associated confused, agitated, hallucinated, and possibly delusional mental state would be diagnosed as an "acute brain syndrome" or delirium. On the other hand, prolonged emotional or mental stresses may cause persistent physiologic bodily disturbances and then produce a secondary structural change of the body; for instance, an ulcer of the stomach. Here too, both the emotional stress that had a causative role, as well as the resultant anatomic disorder of the stomach may need to be diagnosed or classified separately as a "gastrointestinal psychophysiologic disorder" and as a "gastric ulcer." Many examples of such interdependence of physical and mental disturbances can be given in which either or both a mental and physical disorder would be appropriately diagnosed. While we diagnose and classify as mental or physical that particular aspect of an individual's functioning primarily or most markedly strained or disordered, his whole organism is affected by the illness. When we diagnose and classify a "disorder," especially when it is "mental," in a sense, we also classify the individual affected by it.

Between the extremes of well-being and illness there are all gradations of good or healthy adjustment and of partly abnormal or pathological functioning. In the same person "health" may, at various times, be intertwined with "disorder" in different areas of behavior. Even the most severely ill mental patients are said to have some relatively undisturbed functions, and the "healthiest" individual may have some "neurotic" or "abnormal" elements in his adjustment. Between the area of a distinctly healthy mental adjustment and the area of gross mental disturbance there is a broad band in which people are neither clearly mentally ill nor clearly free of psychic disturbance. "Healthy" individuals, who have developed "mature" functioning, are able to cope readily with the stresses of their everyday life, are able to assume the responsibilities of caring for themselves, are able to associate with others as relatively independent beings in a mutually cooperative re-

lationship of giving and taking, and are able to deal with their wants and needs satisfactorily. They are able to manage stresses by choosing from a fair repertoire of reactions available to them that behavior which is most suited to the current and actual situation. In contradistinction to this, people with mental disorder are likely to have experienced in their development stresses with which they coped by warping their maturation so that they remained vulnerable to disturbances in dealing with stressful situations in their later life. By tending to react ineffectively with inappropriate, inadequate, or inflexible patterns of behavior they remain handicapped in their efforts to supply their needs and to eliminate inner stresses. Their life adjustment may show chronic or recurrent disturbance within themselves or in their relation with others. If this is significant enough in degree to be grossly manifest, we are likely to diagnose them as having a "mental disorder." Such precarious or unstable adjustments at times become still more seriously disturbed by situations, which for most people represent little or no stress. This additional gross or acute disruption of mental functions may then need to be diagnosed and classified differently than before. For example, a person getting along fairly successfully and comfortably but who is required to expend much of his energy and time to maintain a life of unvarying regularity, strict punctuality, orderliness, and cleanliness would be classified under the group of "Obsessive-Compulsive Personality Disorder." If for some reason this behavior should become impossible or prove insufficient to maintain his adjustment, he would react with a further mental disturbance still more handicapping or incapacitating. This would require that he now be classed in the group of "neuroses" or perhaps "psychoses." Under circumstances particularly stressful for him, a previously "healthy" or well-adjusted individual may also suffer adaptive failure. This may occur gradually and insidiously or suddenly; it may be temporary or prolonged. This "mental disorder" manifests itself as a change in the intensity, appropriateness, or coordination of his thoughts, feelings, and behavior, so severe in degree and persistence that his capability and effectiveness for living in the environment are seriously impaired. No matter how marked his "disorder" may be, its manifestations do not consist of any essentially different mental activities than those found in health. His mental reactions are abnormal in that they are grossly exaggerated in degree or duration, inappropriate for his age or situation, or so uncoordinated that effective behavior for adjustment fails. The differentiation between health and illness therefore involves our judgment as to

how appropriate and effective a person's reactions are in his situation. In the transitional stages between health and "disorder," these judgments may indeed often be difficult or uncertain at any one time.

How did the classification of mental disorders develop?

The division of mental disorders into classes is still relatively primitive. It varies from country to country and the International Statistical Classification of Diseases, officially adopted by all countries belonging to the World Health Organization, is nearly universally ignored by psychiatrists of these nations. These countries, including the United States, report to the World Health Organization by converting to the international code their varying local classifications which their psychiatrists continue to use in their practices, teaching activities, and communications with each other. This preeminence of the various national classifications, which reflect sectional traditions and parochial needs, indicates that we still lack generally acceptable theoretical concepts on which a universal classification could be based. It also reflects the relatively recent and still limited expansion of our knowledge of mental functioning and of psychiatry.

Prior to the last few decades psychiatry dealt almost exclusively with the "insane" and hospitalized mental patients. Since the beginning of the nineteenth century a number of attempts were made to isolate and classify the mental disorders of these patients. These involved descriptions of combinations of major symptoms or the occurrence of mental disorders in connection with some events or periods in the life of the patients as, for example, senile psychosis, puerperal (childbirth) psychosis, typhoid delirium, etc. Concepts used in classifications were generally related to some major manifestation, to some theories of specific causes, to time and circumstances of outbreak of the disorder, to the course it took, or to some treatment method used. In keeping with the ideas in the last century mental disorders were conceived as specific diseases, often with single causes, engrafted on people and independent in their manifestations from the persons suffering from them. About seventy years ago Emil Kraepelin, the German psychiatrist, formulated a general classification of mental illnesses, based on extensive observations of predominantly hospitalized psychotic patients, into which he incorporated the then-known types of disorder. This classification gained much acceptance and, with some modifications, is still currently applied to the psychoses. The criteria for classification he used involved concepts about the course, the prognosis, and

the obvious manifestations of the disorders. This classification did not deal with any basic psychological concepts and was primarily descriptive in nature. Freud and the psychoanalysts in this century have been the major contributors to the formation of theoretical concepts about the development, the "structure," and the functioning of the mind, and of the manner of production or the nature of its disorders. Beginnings have since been made to formulate classifications based on such psychological concepts. These have been introduced especially into the classification of those mental disorders with which psychiatrists have had to deal increasingly in the last three or four decades—namely the psychiatric problems other than the psychoses of patients hospitalized in mental institutions.

With the expansion of psychiatric practices and activities, the need for the addition of new major classes of mental disorder, as well as for finer subdivisions of some previously established classes increased. The official American Classification in the *Statistical Manual for the Use of Hospitals for Mental Diseases*, first formulated in 1917, was revised considerably in 1934 and had to be still more extensively expanded in 1952. The section on Mental Disorders of the International Statistical Classification of Diseases, first published in 1948, has since also been augmented to meet the current needs. These present classifications still use largely the observed manifestations or symptoms as a basis for the grouping of mental disorders, but the use of theories or principles regarding the origins, methods of production, and results of these disturbances in the affected individual has been introduced in part. For example, the A.P.A. (American Psychiatric Association) classification uses a concept regarding causation to differentiate the "Organic Brain Disorders" from other mental disorders. The "Psychoneurotic Disorders" are subdivided according to the major mental "defense mechanisms" employed by the patient. Prognostic criteria are involved in separating the "Acute Brain Disorders" from the "Chronic Brain Disorders." The various criteria or concepts are employed, rather unevenly, in the classification of Mental Disorders. While the current classification still depends largely on descriptive data, the clustering of the directly observable manifestations, and of their progression or "course," they do also incorporate some concepts derived from our knowledge of etiological or causative factors and of dynamics or mechanisms of production of mental disturbances, as well as from our theories of maturation and development of the mental apparatus. A regular correspondence or linkage between causative or dynamic factors and

observed manifestations is expected in nature so that the more correct and fundamental the principle is by which the mental disorders are divided, the more similarities are likely to be found among the various characteristics of each group.

The current A.P.A. classification will undoubtedly be revised as further knowledge brings better theories and as changed usages lead to other demands. At present it reflects the current concepts of multiple causal factors, of an interplay of a variety of dynamic elements struggling for an equilibrium, and of blurred boundaries between the disorders. It divides all mental disorders into two major groups: those associated with diffuse damage of brain tissue, the "organic" brain disorders, and those in which there is no evidence of such destruction or damage, the "functional" mental disorders. The organic brain disorders are further divided into those in which the brain damage is temporary, reversible, or acute, and those in which it is permanent, irreversible, or chronic. The functional mental disorders are separated into the major groups of psychoses, psychophysiologic disorders, neuroses, personality disorders, and the transient situational reactions. The mental deficiencies that formed a large separate major division in the earlier classifications are now mostly absorbed by the chronic brain syndromes. In the previous American Classification and the current International Statistical Classification of Diseases all mental disorders are primarily divided into psychoses, neuroses, personality disorders, and mental deficiencies. Any brain disorder present is secondarily added to the diagnosis, e.g., "psychosis with cerebral arteriosclerosis." The present A.P.A. classification, on the other hand, employs the concept that brain damage regardless of cause produces essentially the same primary mental disturbance, the "organic brain syndrome," which may or may not be accompanied by additional manifestations of a psychotic, neurotic, or behavioral character in different individuals or at different times in the same person. Such further symptoms are regarded as being "released" or activated by, and superimposed on, the basic organic brain syndrome. A similar assumption is made with the personality disorders, the mental deficiencies, and other mental disorders. Appropriate "qualifying phrases" are therefore provided, which may be added to the "basic" mental diagnosis to indicate the presence of complicating reactions that significantly alter the primary illness. This manner of classifying represents our current theoretical concepts and permits a sharper description of the individual cases seen in practice and their finer grouping for later study. The introduction of this classificatory

method has, however, met with some resistance from statisticians and has not been uniformly used so that it may need to be modified in the future.

What are the characteristics of the major groups of mental disorder?

The A.P.A. classification will be used in discussing this question. The characteristics found in the distinct or "typical" members of the various classes will be presented. We need to remember, however, that the reactions and the behavior of different individuals with the same class of mental disorder will vary considerably depending on the many variable factors in their particular inheritance, development, and experience.

A) The *Organic Brain Disorders* are differentiated from the other mental states in that they are linked with demonstrable diffuse damage to the brain tissue, either structural and permanent or functional and temporary. A person with intoxication by alcohol or sedatives has a reversible brain tissue damage which is temporary, representing a type of "Acute Brain Disorder." When his damaged brain tissue is caused by a senile atrophy or severe arteriosclerosis, it is permanent and largely irreversible and the disturbance is an example of a type of "Chronic Brain Disorder." The mental manifestations in both instances are those of diminution of memory, of capacity for orientation in the environment, of forming judgments, of performing all intellectual tasks, and of depth and persistence of feeling tones. The impairment in all these areas is similar in degree and roughly proportional to the amount of damage to the brain. These mental phenomena are the basic, necessary, and only characteristics of all organic brain disorders and are called the "Organic Brain Syndrome." These "organic brain syndromes" are essentially alike no matter what caused the damage to the brain tissue. The "acute brain disorders" may have a very short or more prolonged time for recovery; the "chronic brain disorder" persists and if the brain damage increases may become more severe in degree. These basic disturbances in mental functioning in the organic brain disorders may, and usually do, remain the only manifestations of the disorders or may have other symptoms superimposed on them. These added associated or "released" mental disturbances depend on factors in the person affected and vary according to his personality, the kind of character traits and problems or stresses he developed and carried with him through his life, according to the methods he evolved for dealing with these in the past, as well as according to the impact of his immediately

current situation. Thus, there may be superimposed or accompanying an organic brain syndrome groups of mental phenomena which are characteristically found in the "functional" mental disorders such as the psychoses, neuroses, or personality disorders. The severity of these superimposed or associated mental disturbances is largely independent and not proportional to the degree of the basic organic brain disorder. Usually they recede with the disappearance of the acute organic brain disorder, but they may persist independently. With the chronic brain disorders these superimposed disturbances are likely to run an independent course and may appear or recede without any change in the organic brain disorder. When the brain is permanently damaged early in the life of an individual, he shows not only the usual manifestations of an organic brain syndrome but also a warping of his intellectual development and is then subclassified as having a chronic brain disorder "with mental deficiency." Both the acute and chronic organic brain disorders are further subclassified according to the cause of brain damage that produced them.

Mental Deficiency is a term with legal as well as medical significance which is well ensconced in our vocabulary. When severe, this disorder is always associated with brain damage early in life and is then classed with the chronic brain disorders. In some milder defects of intellectual functioning present since early childhood, no anatomic brain damage can be demonstrated, and therefore the separate class of "Mental Deficiencies" is retained to accommodate such cases without forcing them into the organic brain disorders. The Mental Deficiencies are subdivided according to the presence or absence of known hereditary factors. They may be further classified as to severity as determined by specific intelligence test results.

B) The "*Functional*" *Mental Disorders* are not associated with any distinct or clearly demonstrable physical disturbance. They are divided into the *psychoses*, *psychophysiologic disorders*, *personality disorders*, and *transient stress disorders*.

The *Psychoses* are mainly characterized by a marked and persistent disturbance in the relationship of the individual to the people and things in his environment. His conception of, and reaction to, phenomena in his environment is predominantly determined by factors within himself and is not easily correctible by stimuli from without. This may involve all of his relations to people and things around him or may, as in paranoid conditions, be limited to some specific classes of objects, situations, or ideas. Other general characteristics associated

with psychoses are persistent, more or less pervasive substitution of developmentally primitive behavioral and thinking processes for the more "mature" ones previously present, or expected, in this individual. A psychosis may be temporary and reversible or may persist and continue to involve more of the thinking, feeling, and behaving of the individual as time goes on. The psychotic depressions, for instance, are generally completely reversible within several months. The person in this mental state perceives and reacts to the world not in his usual manner of receiving, testing, and evaluating the external stimuli and responding to them realistically. His depressed mood makes him feel as if everything were really bleak, dire, hopeless, accusing, threatening, rejecting, etc. In schizophrenic patients the reaction to the world outside may vary from almost complete rejection of, or indifference to, external stimuli as in hebephrenic types, to an apparently "normal" perception of most occurrences except that they are interpreted as relating to, and supporting, some delusional ideas as in paranoid types. With such a psychologically imposed persistent isolation of the person from his real current environment, and with his regression to primitive mental functioning, a schizophrenic patient becomes difficult to understand and to influence in treatment and may remain permanently estranged from his surroundings or "demented."

The psychoses are subdivided largely on a phenomenological basis into the major subclasses of "Affective" and "Schizophrenic" Psychoses according to whether a severe and persistent change in mood is pre-eminently apparent or whether the disturbances in thought and behavior are apparently unassociated with such a marked mood swing. The further subdivision of these subclasses into types rests mainly on the character of the major apparent manifestation or symptoms.

The *Psychoneuroses* have the common characteristic of showing changes in the affected person consisting of his persistently modifying, thwarting, limiting, or overusing some mental reactions in order to cope with, or avoid, the experience of anxiety or fear without gross loss of contact with reality. This is generally conceived to be an inner struggle, of which the person is unaware, between some persistent or recurring impulses, strivings or demands on the one hand, and the individual's attempts to control, thwart, or modify them, on the other hand. These conflicts, as well as some of the methods of dealing with them, originate in early life and are not currently appropriate. The struggle may have been quiescent or in a practical "stalemate" and

then reactivated by recent stressful experiences or circumstances. These revive in him some past reactions of vulnerability to threats, with an imminent experience of "anxiety," against which he tries to protect himself automatically by the use of his characteristic psychic defense mechanisms. This struggle may preempt so much of his energies and cause so much limitation or modification of his behavior that it becomes severely handicapping. Some distortion in his concepts of current reality, as well as a considerable disturbance in freedom of reacting to the immediate actual realistic situations, may be evident but this is generally recognizable or correctible, at least on a conscious level, and does not constitute a gross disruption of contact with realities. For instance, in "obsessive" neurosis the person may wish to free himself of a persistent thought, which he knows to be unreasonable or inappropriate, but the thought keeps recurring. Also in "anxiety" neurosis the person may know that there is no actual external danger and no reason to feel frightened at all. His perception of reality is preponderantly conventional but his unrealistic response, dictated by inner and unconscious factors, persists in spite of his "knowledge."

The psychoneuroses are subdivided according to the main psychological method employed in avoiding anxiety or the chief "defense mechanism" against the threatening impulses. They are named after their major defense as the "Conversion" and "Dissociative" Reaction, or for their major manifestations as the "Anxiety," "Phobic," "Obsessive-Compulsive," and "Depressive" Reaction.

The *Psychophysiologic Disorders* are characterized by persistent disturbances in the functioning of some organs or organ systems of the body that are, at least to a major degree, caused by developmental and current mental factors. As far as we know at the present time, these disorders originate in very early disturbances of mental development in the affected individual. These facilitate the reactivation of early infantile connections between the functions of various organs and emotional states. When long persistent, these physiological disturbances in the function of organs may produce structural changes in them that may become dangerous to life. Examples of hypertension, ulcer of the stomach, or ulcerative colitis may be cited. The organs generally subject to psychophysiologic disorders are those not under voluntary control.

The psychophysiologic disorders are subdivided according to the anatomic systems primarily involved.

A differentiation between the term "psychosomatic" and "psycho-

physiologic" might be mentioned here. Currently, the term "psychosomatic" generally denotes the attitude of considering both the psychic and physical aspects of any illness, whereas the term "psychophysiology" refers more specifically to persistent changes in the functioning of some organs or systems that are in part traceable to the mental life of the individual.

The *Personality Disorders*, in contradistinction to the other disorders, do not occur or develop in people who had previously functioned satisfactorily but are essentially lifelong patterns of behavior evolved like character traits early in life and remain obligatory or more or less fixed in later life. They involve overt behavior in which attempts to change or manipulate the environment are more prominent than efforts at changing or modifying one's own reactions. In these situations conflicts with society often result and cause further stress. Such personality disorders may also become more manifest or aggravated by the stresses of the different age periods or of different life situations. Additional symptoms may then supervene, at times similar to psychoses or neuroses, that further incapacitate the individual.

The personality disorders are subdivided chiefly according to their major manifestations. One group contains several types of exaggerated personality pattern, trait, or character disturbances, namely: "Schizoid," "Cyclothymic," "Paranoid," "Immature," "Hysterical," "Passive-Aggressive," and "Compulsive" Personality types. Another group contains types of Personality Disorder characterized by conflict with society. These include: the "Antisocial" Personalities, the "Sexual Deviations," and the "Addictive" types. Still another group contains types with single symptom manifestations such as enuresis, learning or speech disturbance, etc.

The *Transient Situational Reactions* may show manifestations similar to psychoses, neuroses, or the personality disorders. Here they are released by some gross sudden (though generally temporary) stress on the adaptive capacities of the individual. This stress may be imposed from the outside, such as the prolonged stress of combat, or the sudden severe stress of the loss of one's family by an accident. However, it may also be precipitated in some individuals by internal stresses related to such developmental situations as puberty, retirement, or to such events in mature life as marriage or childbirth. These individuals are distinguished from those with other disorders by two further factors: (1) that their previous adjustment and capacity for adjustment were

generally within normal limits; and (2) that when the stress is no longer present they tend to return spontaneously to their usual good health.

An outline of the current American Classification of Mental Disorders follows.

MENTAL DISORDERS*

DISORDERS CAUSED BY OR ASSOCIATED WITH IMPAIRMENT OF BRAIN TISSUE FUNCTION

Acute Brain Disorders

1. Due to or associated with infection
2. Due to or associated with intoxication
3. Due to or associated with trauma
4. Due to or associated with circulatory disturbance
5. Due to or associated with disturbance of innervation or of psychic control
6. Due to or associated with disturbance of metabolism, growth, or nutrition
7. Due to or associated with new growth
8. Due to unknown or uncertain cause
9. Due to unknown or uncertain cause with the functional reaction alone manifest

Chronic Brain Disorders

1. Due to prenatal (constitutional) influence
2. Due to or associated with infection
3. Associated with intoxication
4. Associated with trauma
5. Associated with circulatory disturbance
6. Associated with disturbance of innervation or of psychic control
7. Associated with disturbance of metabolism, growth, or nutrition
8. Associated with new growth
9. Associated with unknown or uncertain cause
10. Due to unknown or uncertain cause with the functional reaction alone manifest

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MENTAL DEFICIENCY

1. Mental deficiency—familial or hereditary
2. Mental deficiency—idiopathic or of unknown origin

DISORDERS OF PSYCHOGENIC ORIGIN OR WITHOUT CLEARLY DEFINED STRUCTURAL CHANGE

Psychotic Disorders

- A. Affective psychotic reactions
 1. Manic-depressive reaction, manic type
 2. Manic-depressive reaction, depressive type
 3. Manic-depressive reaction, other
 4. Psychotic depressive reaction
 5. Involutional psychotic reaction
- B. Schizophrenic reactions
 1. Simple type
 2. Hebephrenic type
 3. Catatonic type
 4. Paranoid type
 5. Acute undifferentiated type
 6. Chronic undifferentiated type
 7. Schizo-affective type
 8. Childhood type
 9. Residual type
 10. Other
- C. Paranoid reactions
- D. Psychotic reactions, other than above
- E. Psychotic reaction, unclassified

PSYCHOPHYSIOLOGIC DISORDERS

- A. Psychophysiologic reaction, generally or unclassified
- B. Psychophysiologic skin reaction
- C. Psychophysiologic musculoskeletal reaction
- D. Psychophysiologic respiratory reaction
- E. Psychophysiologic cardiovascular reaction
- F. Psychophysiologic hemic and lymphatic reaction
- G. Psychophysiologic gastrointestinal reaction
- H. Psychophysiologic genitourinary reaction

- I. Psychophysiologic endocrine reaction
- J. Psychophysiologic nervous system reaction
- K. Psychophysiologic reaction of organs of special sense

PSYCHONEUROTIC DISORDERS

Psychoneurotic Reactions

- A. Anxiety reaction
- B. Dissociative reaction
- C. Conversion reaction
- D. Phobic reaction
- E. Obsessive-compulsive reaction
- F. Depressive reaction
- G. Other psychoneurotic reaction

PERSONALITY DISORDERS

- A. Personality pattern disturbance
 - 1. Inadequate personality
 - 2. Schizoid personality
 - 3. Cyclothymic personality
 - 4. Paranoid personality
 - 5. Immature personality
 - 6. Emotionally unstable personality
 - a. Passive-aggressive type
 - b. Passive-dependent type
 - c. Aggressive type
 - 7. Compulsive personality
 - 8. Hysterical personality
 - 9. Other personality pattern disturbance
- B. Sociopathic personality
 - 1. Antisocial personality
 - a. Violent type
 - b. Stealing type
 - c. Cheating type
 - d. Other specified types
 - 2. Dissocial personality
 - 3. Sexual deviation
 - a. Homosexual type
 - b. Voyeur-exhibitionist type
 - c. Other types

4. Addiction
 - a. Alcohol addiction, chronic
 - b. Drug addiction
 - c. Alcohol and drug addiction, combined types
- C. Special symptom disturbance
 1. Hearing disturbance
 2. Speech disturbance
 3. Enuresis, persistent
 4. Somnambulism
 5. Other special symptom disturbance

TRANSIENT STRESS DISORDERS

- A. Gross stress reaction
- B. Adult situational reaction
- C. Adjustment reaction of infancy
- D. Adjustment reaction of childhood
- E. Adjustment reaction of adolescence
- F. Adjustment reaction of late life
- G. Other transient stress reaction

QUALIFYING PHRASES

- A. Unqualified
- B. With psychotic manifestation
- C. With neurotic manifestation
- D. With behavioral manifestation
- E. With mental deficiency
- F. With mental deficiency and psychotic manifestation
- G. With mental deficiency and neurotic manifestation
- H. With mental deficiency and behavioral manifestation
- I. With psychophysiologic manifestation
- J. With mental deficiency and psychophysiologic manifestation

MENTAL DISORDERS IN THE UNITED STATES

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One of the characteristics of this era is the contrast between physical health and mental health. If we measure the former by statistics of mortality we observe a steady *decline* in death rates since the beginning of the century and a corresponding *increase* in longevity and in the expectation of life. We cannot say the same of mental health, especially as it is measured by statistics of mental disorders. Partly because of the triumphs of public health, larger and larger numbers of Americans are becoming mentally ill. This is due not only to the fact that the increase in the length of life contributes to a larger population, but also that it does so at the stage of life when the vulnerability to such disorders is greatest.

PREVALENCE OF MENTAL DISORDERS

The frequency of mental disorders usually is measured either by its prevalence on a stated date or by the number of new cases (annual incidence) arising during a given period—usually a year. Such statistics, however, were not available prior to the census of patients in mental hospitals undertaken by the Bureau of the Census in 1923. Before this date, statistics of mental disorders referred to prevalence, meaning the number of patients in mental hospitals (usually under public auspices) on a specific date. Inasmuch as mental hospital patients have long average periods of hospital residence, this group until recently has tended to grow, and has exceeded the number of patients with acute physical disease who are under treatment in general hospitals. This situation has been the basis for the oft-quoted statement that more than half of the hospital beds in the United States are occupied by patients with mental disorders. Because of the chronic character of much mental illness this comparison is true. But the implication that the true probability (incidence) of mental disorders is greater than for most other diseases must be held in proper perspective.

True prevalence on a specific date would include all mentally ill persons, whether hospitalized or not. Some attempts have been made, especially in the Scandinavian countries, to include under prevalence even some persons who may have received no treatment at all, but who were diagnosed in the community by competent field investigators. Conditions for such studies are favorable in Scandinavia, but are not equally suitable in the United States.

Nevertheless, attempts have been made to estimate the prevalence of mental disorders in the United States. Such an enumeration was made by the United States Public Health Service in 1935 and 1936, in a house-to-house canvass in selected, primarily urban, communities. All cases of disabling illness lasting a week or more were counted and the United States Public Health Service found that 12,627 persons were suffering from a "nervous" disorder. This was the equivalent of a rate of 549 per 100,000 population.

Other estimates were derived from Selective Service statistics. The first such report was issued in 1941 and dealt with 19,923 examinations. Of this total, 362—or 18.2 per 1,000 persons examined—were said to have a mental disorder. A second report, based upon examination of 121,966 men, recorded that 2,868 men had mental disorders, a rate of 23.7 per 1,000. A third report, issued in 1944, was based upon examinations of approximately 1,800,000 men. Probably because medical standards had become more rigorous, the rate of mental disorders amounted to 67.5 per 1,000 examined. However, such estimates could not be generalized because they applied only to males and to restricted age categories.

Other estimates were made after field investigations of greater intensity and refinement. The best known are the studies in the Eastern Health District of Baltimore, and in Williamson County, Tennessee. Assuming the adequacy of definitions, which included adult delinquency as a mental disorder, the Baltimore survey provided a prevalence rate of 60.5 per 1,000 persons examined. The Tennessee survey, which dealt mainly with a rural population, on September 1, 1938, reported 1,728 cases of mental disorder, or a prevalence rate of 69.4 per 1,000 persons examined. In recent years there have been several somewhat similar investigations, such as those in Syracuse, New York, the New Haven Metropolitan area, and the Yorkville section of Manhattan. None of these studies can be generalized, however, so as to give a consistent estimate of prevalence of mental disorders for the population of the United States.

In some cases, as with communicable diseases, it is possible to obtain statistics of prevalence by making the reporting of such cases compulsory. However, this is not yet feasible in the reporting of mental disorders. Therefore, it is necessary to rely mainly on the count of the mentally ill who are admitted to, and treated in, hospitals. The hospital count is, in fact, the historical method of obtaining statistics about the mentally ill.

The first attempt to measure prevalence in the United States was made in connection with the general census of population in 1850. Mental patients were counted not only in mental hospitals, but also in private residences. Similar counts were made in 1860 and 1870. According to these censuses there were 15,610 patients with mental disorders in 1850, 24,042 in 1860, and 37,432 in 1870. The number per 100,000 population increased from 67.3 in 1850 to 97.1 in 1870. However, these censuses were all seriously defective.

The first census to be considered relatively reliable was the census of 1890, which included a total of 91,959 mentally ill persons, of whom 51,017 were not hospitalized. Beginning with 1904, the census of mental patients was limited to hospitals. In that year, there were 150,151 patients, or a rate of 183.6 per 100,000. According to the census of 1910 there were 187,791 in hospitals, a rate of 204.2 per 100,000. The census of 1923 showed a population of 267,617 in mental hospitals, or a rate of 245.0 per 100,000.

Such statistics were compiled annually from 1926 to 1947 by the Bureau of the Census, and have been recorded since then by the National Institute of Mental Health. The number of patients in public hospitals for the prolonged care of the mentally ill increased during these years, and by the end of 1958 there were 536,585 patients in such hospitals, or 307.3 per 100,000 of population. In addition, there were 8,957 patients in family care, and 101,110 in other care outside of hospitals.

Patients in all hospitals for mental disorders (except veterans hospitals) in the United States in 1950 represented a rate of 412.6 per 100,000. This varied from a minimum of 264.1 in the East South Central states (Kentucky, Tennessee, Alabama, and Mississippi) to a maximum of 551.7 in the mid-Atlantic division (New York, New Jersey, and Pennsylvania). The New England states had a rate of 540.1. The Pacific division, too, had a relatively high rate of 403.6.

The rates for individual states varied from a minimum of 203.9 in New Mexico to a maximum of 848.4 in Montana. In general, how-

ever, most of the low rates occurred in the southern states. Alabama had a rate of 239.5; Tennessee, 242.9; Florida, 268.1. High rates occurred in New York State, 676.9; Massachusetts, 590.0; Illinois, 471.2; California, 420.4.

ANNUAL INCIDENCE OF MENTAL DISORDERS

But though statistics of patients in mental hospitals indicate an increase in the number of patients and a corresponding increase in their ratio to the general population, they do not give a proper measure of the probability of mental disorders, which comes rather from annual statistics of new (or first) admissions to these hospitals. Such data were first reported for the United States in 1922, when there were 71,676 first admissions to all mental hospitals in the United States, or a rate of 68.2 per 100,000 of population. The rate of first admissions has risen since that year. In 1950 and 1951 there were 308,975 first admissions, or an average annual rate of 102.5 per 100,000. A still clearer trend is seen in New York State, where the rate of first admissions to the State civil hospitals rose from 60.4 per 100,000 in 1910 to 106.0 in 1950.

During 1950-1951, the average annual rate of first admissions rose from a minimum of 70.4 per 100,000 in the West South Central states (Arkansas, Louisiana, Oklahoma, and Texas) to a maximum of 147.1 in the Pacific states (Washington, Oregon, California). In general, the rates were lowest in the South Atlantic and East South Central states (southern divisions) and highest in the New England and Middle Atlantic states (northeastern divisions).

Among individual states, the rates varied from a minimum of 32.0 in Kansas to a maximum of 221.0 in Colorado. Most of the states in the northeastern divisions had rates above the average; for example, Massachusetts, 153.3, Connecticut, 138.0. New York had a rate of 128.2. California had a rate of 164.1. In general, low rates occurred in the southern states. Alabama had a rate of 54.4; Louisiana, 78.7; Texas, 55.5.

The contrast between North and South stems in part from the more extensive hospital facilities in the North, and the resulting tendency toward more frequent hospitalization. But, in addition, southern states have a higher proportion of persons in younger age brackets where the rates of first admissions are lowest. On the other hand, rates are highest in the industrialized and urban areas of the North and East North Central divisions. On the Pacific Coast rates are

high, largely as a result of migration. The inference, therefore, is that rates of first admissions are lower in the South, but that this is partly spurious.

EXPECTATION OF MENTAL DISORDERS

The annual rates of first admissions tell us the chance of being admitted to a mental hospital within a specified year. But a more important measure is that which shows the chance of being admitted at any age during a specified period. For example, what is the chance at birth that a person will be admitted to a mental hospital sometime during his life? Such a probability is known as the expectation of mental illness at birth. This expectation depends upon the chance of developing a mental disorder at any specified age. Whether a person of a given age develops a mental disorder at a later age clearly depends upon whether he lives to that age. Therefore, the expectation of mental illness is the result of a combination of the forces leading to mental illness and to mortality.

According to the rates of first admissions and of mortality in New York State in 1920, out of every 1,000 males born, 48.2 would be admitted to a mental hospital before the entire group died out. This is equivalent to 1 out of every 20.7. In 1930, the expectation of mental illness at birth was 68.9 per 1,000, or 1 in 15.6, an increase of 33 per cent during the decade. In 1940, the expectation of mental illness at birth rose to 80.9 per 1,000, or 1 in 12.4.

In 1920, the expectation of mental illness at birth among females in New York State was 48.1 per 1,000 females, or 1 in 20.8. By 1930, the expectation increased to 55.8 per 1,000, or 1 in 17.9. In 1940, the expectation was 82.0 per 1,000, or 1 in 12.2.

There are no statistics of the expectation of mental illness since 1940, but mortality rates have declined, in general, and rates of first admissions have increased. Therefore, it is certain that the expectation of mental illness has increased, and a conservative estimate must now place the expectation of mental illness at birth as at least 1 in 10.

The statistics on the expectation of mental illness clearly show one of the unusual features of public health: as public health improves, as measured by the decline in mortality rates, the expectation of mental illness increases. As the diseases of childhood are controlled, more individuals will survive to youth and early adulthood, and therefore, other things being equal, there will be a relative increase of schizophrenia. As the diseases of the third and fourth decades of life are

brought under control, more of the population will survive to middle age and will be exposed to the mental disorders of that period. And finally, as science controls the diseases of middle age, there will be an increase in the number of persons surviving to old age, and therefore an increase in the psychoses of old age.

CLINICAL DIAGNOSES

Data concerning the distribution of types of mental disorders are available for 290,513 first admissions to all mental hospitals in the United States during 1950 and 1951. The largest single category of diagnosis—65,791 cases or 22.7 per cent—was schizophrenia. The psychoses of advanced age totaled 66,573 and included 36,384 cases of psychoses with cerebral arteriosclerosis, and 30,189 cases of senile brain disease, representing 12.5 per cent and 10.4 per cent, respectively, of total first admissions. Other groups were: psychoneuroses—21,033, or 7.2 per cent; manic-depressive psychoses—19,516, or 6.7 per cent; involutional psychoses (associated with menopause in women and climacteric in men)—18,184, or 6.3 per cent; and alcoholic psychoses—11,814, or 4.1 per cent.

This may be compared with the corresponding distribution for New York State during 1949 to 1951, inclusive. Schizophrenia was diagnosed in 16,677 first admissions out of a total of 57,713, or 28.9 per cent. Psychoses with cerebral arteriosclerosis and senile brain disease amounted to 18.6 per cent and 12.9 per cent, respectively, of total first admissions. The manic-depressive psychoses were low, accounting for only 4 per cent of the total. Other groups were distributed as follows: psychoneuroses, 6.2 per cent; involutional psychoses, 8.7 per cent; alcoholic psychoses, 5.7 per cent.

In general, there has been an upward trend in annual rates of first admissions in New York State and in the United States. This has been due primarily to increased incidence of mental disorders associated with advanced age, especially psychoses with cerebral arteriosclerosis and senile brain disease. However, schizophrenia, a disorder of younger age brackets, has also shown a rising trend. On the other hand, general paresis and manic-depressive psychoses have shown declining trends.

AGE

It has been maintained by some that age is correlated so highly with the diagnosis of a psychiatric disorder that it could be used as a significant guide to clinical diagnosis. This appears, at first, to be an

unreliable guide, since the rate of first admissions increases, with minor variations, from a minimum at ages under fifteen to a maximum at advanced ages. However, this is an *average of the trends* for each of the major groups of mental disorders. Only psychoses with cerebral arteriosclerosis and senile brain disease show a steady rise in incidence as age advances. The other groups of mental disorders are limited primarily to certain age categories. They rise to maximum incidence at different ages and decline at subsequent ages. In New York State, general paresis, for example, rises to a maximum at ages fifty to fifty-nine. Alcoholic psychoses rise to a maximum at ages forty to forty-nine. The manic-depressive psychoses have a lower age range and reach a maximum incidence at ages thirty-five to forty-four. Schizophrenia has a still lower age range, and reaches a maximum rate in the late twenties and early thirties. Each period of life, therefore, appears to be susceptible to certain characteristic types of mental disorders.

URBAN-RURAL DISTRIBUTION

It is well known that disease varies in frequency in relation to the size of population. Generally, death and morbidity rates are lower among rural populations. This can also be demonstrated with respect to mental disorders. In New York State, rates of first admissions to mental hospitals increase from minimum rates of rural populations to higher rates of the larger cities.

New York State had an average annual standardized rate of 167.0 per 100,000 population in 1949-1951. The urban rate was 184.0, compared with only 97.7 for the rural population. Though there is not a completely regular progression in the rates, it is known that smaller cities tend to have lower rates than larger cities, and that all cities have higher rates than the rural population.

Of special interest in the rural statistics are the higher rates of mental hospital first admissions of the farm population, as compared with the nonfarm population. This may be related to population movements. Migration to suburban areas adjoining metropolitan centers takes with it a large proportion of persons who pursue non-farming activities and who are of a higher economic status than farmers. Studies by this writer and others have shown that, in general, the better educated classes who are engaged in generally recognized higher occupations have lower rates of mental hospital first admissions than populations with little or no education or with lower occupational status. Suburbs include populations of a higher social class based on

the criteria of education and economic status. Consequently, we would expect the nonfarming population, which includes suburbanites, to have a lower rate of first admissions than the farm population.

The higher rate of first admissions among urban populations is generally admitted, but many refuse to admit a corresponding higher incidence of mental disorders on the grounds that it is readily possible for the mentally ill to live at home in rural areas, whereas those with similar symptoms in urban areas would be hospitalized because of their disturbing influences on the community. As usually presented, this is only an unverified hypothesis.

Some evidence was therefore sought by examining the duration of symptoms prior to hospitalization. If the chance of hospitalization is less in rural areas than it is in the city, then, by the same token, it should be possible to maintain such patients at home in rural areas for longer periods prior to hospitalization. Thus, the duration of a psychosis before hospitalization should be greater for patients from a rural environment.

Using broad categories in measuring the time interval, it appeared that 59.1 per cent of urban first admissions to mental hospitals in New York State during 1949-1951 had been ill less than a year prior to hospitalization, and that 11.2 per cent had been ill for 5 or more years. The median duration was 5.9 months. The corresponding statistics for rural first admissions were: less than a year, 58.1 per cent; 5 or more years, 11.8 per cent; median duration, 6.2 months.

The differences are slight, and it must be concluded that anyone developing a mental illness in a rural environment will, on the average, be admitted to a mental hospital within the same time limits as one from an urban environment. This would not appear to be possible if there were important differences in attitudes toward the mentally ill. It is therefore concluded that the differences in rates of first admissions between urban and rural areas are genuine, and are not derived from different attitudes toward mental illness and the desirability of hospitalization.

SOCIAL STATUS AND INCIDENCE OF MENTAL ILLNESS

In their analysis of the distribution of mental illness in Chicago, Robert E. L. Faris and H. Warren Dunham showed that, in general, the incidence of first admissions to mental hospitals decreased as one passed from the central area of the city to the peripheral sections. Since there was an improvement in the residential character of the

districts as one passed radially from the center of the city, this implied that there was an inverse relation between residential status and the incidence of mental illness. This gave rise to the concept of a relation between social status and the incidence of mental illness.

Such an analysis requires a grading of the general population into social classes, and a measure of the incidence of mental disorders in such classes. In a broad way, such a classification is available for first admissions to mental hospitals, using economic status as an index of social status. Thus, first admissions have been classified as either dependent, marginal, or comfortable. Dependents are those persons lacking in the necessities of life, or receiving aid from public funds or from persons outside the immediate family. Comfortable refers to those who have accumulated resources sufficient to maintain self and family for at least four months.

On this basis, the first admissions to all mental hospitals in New York State during 1949-1951 were classified as follows: dependent, 24.6 per cent; marginal, 57.2 per cent; comfortable, 18.2 per cent. The general population of New York State was classified with respect to income in 1949. In that year, 17.7 per cent of families and unrelated individuals had an annual income of less than \$1,000. Those with an income of \$5,000 or more included 21.6 per cent of the total. Assuming that these correspond to the dependent and comfortable categories of the first admissions, the classifications imply that the dependent class was overrepresented among the first admissions, whereas the comfortable class was underrepresented.

However, there are important differences in this respect among the major groups of mental disorders. Thus, the dependent classes were heavily overrepresented among first admissions with psychoses with cerebral arteriosclerosis, 41.1 per cent; senile psychoses, 46.2 per cent; and general paresis, 25.3 per cent. On the other hand, first admissions classified as dependent had less than their expected percentages with manic-depressive psychoses and psychoneuroses (5.4 and 9.1 per cent, respectively).

On the contrary, those described as comfortable were overrepresented with respect to involutional psychoses, manic-depressive psychoses, and psychoneuroses, the percentages being 31.8, 38.8, and 34.3, respectively, compared with an expected 21.6 per cent.

Economic status is largely determined by occupation. Variation of incidence of first admissions in occupational categories is therefore corroborative of the variation according to economic status. Thus, a study

in Chicago showed a negative correlation of 0.70 between admission rates for schizophrenia and income, and a negative correlation of 0.81 with occupational prestige.

The total white male labor force of New York State, aged 14 and over, in 1950 had an average annual rate of first admissions of 3.4 per 100,000 of population with respect to general paresis. But the rates varied from 1.1 among professional and technical occupations, and 1.3 among managers and officials, to 5.3 among service workers, and 10.5 among laborers. Thus, the rates were low in occupations that rank high on the economic scale, and high at the other end of the economic scale.

The alcoholic psychoses showed a similar distribution with respect to occupations. Thus, the average annual rate of such first admissions among the white male labor force in 1949-1951 was 18.4 per 100,000. However, the rates rose from 5.5 among professionals, to 7.8 among farmers and farm managers, to 36.1 among service workers, and to 66.8 among laborers. For specific occupations, the rates varied from 4.2 among lawyers and judges, 1.2 among physicians, and 3.8 among teachers, to 17.7 among taxicab drivers and chauffeurs, 38.3 among waiters and bartenders, and 66.9 among longshoremen.

A reverse order of differences occurred among the psychoneuroses. The highest incidence occurred among the higher occupational categories; the lowest rates occurred generally in the lower and unskilled categories.

The influence of social class may also be approached from the viewpoint of education. In general, those with a higher degree of education belong to a higher social class. In our society, those having no education, or only an elementary education, may be considered as having a generally lower social status. On this basis, an inverse relation may be demonstrated between degree of education and incidence of mental illness. In 1939-1941, the highest average annual standardized rate of first admissions to all mental hospitals in New York State, 254.8 per 100,000, occurred among those with no formal education. The rate decreased as the level of education rose.

As with economic status, however, there was a further class differentiation. For schizophrenia, the incidence varied inversely with degree of education. Among manic-depressives, however, the rate rose from 10.9 among those with no education to 16.1 at the college level. For the psychoneuroses, the rates varied from a minimum of 8.3 among

those with no education, to 12.4 among those with some degree of high school education, and to 15.9 among those who had some degree of college education.

Thus, based on two criteria of social status, it is clear that the total incidence of mental illness, as measured by first admissions to mental hospitals, varies from a minimum in the higher classes to a maximum in the lower classes. There is a significant reversal of this trend, however, among several groups of functional mental disorders.

In the preceding comparisons, income, occupation, and degree of education were used as indices of class status. The class incidence was determined by relating first admissions to mental hospitals to corresponding general populations as determined by the federal census of population. It is possible to make more definite comparisons by relating mental cases directly to their parent populations. The most important of such comparisons is that by August B. Hollingshead and Frederick C. Redlich in their study of metropolitan New Haven. They divided the general population into five social classes, based on combinations of occupation, income, education, and residential area. Cases of mental disorders from among this population, admitted for the first time to treatment either privately or to a mental hospital, were classified in a similar manner with respect to social class. The rate of first admissions during a period of six months varied from 97 per 100,000 in the highest classes (I and II), to 114 in Class III, 89 in Class IV, and 139 in Class V, which is the lowest class. The difference between Class V and the higher classes was significant, but this appeared to be a dichotomy (division into two parts) rather than a rising trend.

The first admissions included both psychoses and psychoneuroses. Considering only the psychoses, rates of first admissions rose from 2.8 per 100,000 in Classes I and II, to 3.6 in Class III, to 3.7 in Class IV, and to 7.3 in Class V. For schizophrenia, the rates increased steadily from 6 in Classes I and II to 20 in Class V.

Thus, the existence of class differences in rates of first admissions in New Haven agreed with the findings on the basis of first admissions to mental hospitals in New York State.

Hollingshead and Redlich reported that the incidence of the psychoneuroses did not show a class differentiation. However, the rates were 69 for Classes I and II, and 78 for Class III. The two lower Classes (IV and V) had rates of 52 and 66, respectively. It appears that the three higher classes had a higher combined rate of first admissions than the two lowest classes. It is therefore probable that there is a direct relation

between social class and incidence of psychoneuroses, as was found previously from data for New York State.

It may be concluded that the incidence of mental illness varies significantly among the several social classes into which the general population may be divided. In general, the incidence varies inversely with social class. However, in several groups of disorders, the highest rates occur in the highest social class. Conceivably, such variations may be related to possible biological differences among classes, to differential environments, or to a combination of both. At present, the data do not permit anything more than speculation along these lines.

RACE AND ETHNIC DIFFERENCES

It has been shown that the distribution and frequency of mental disorders are influenced significantly by the age composition of the population, and by the density of population, with special reference to the urban-rural ratio. But incidence of mental disorders is also affected by racial and ethnic characteristics of the population. Little has been reported about this, primarily because of the failure to classify the general population of the United States according to race, other than to make the broad distinction between white, Negro, and other nonwhite groups (i.e., Indian, Chinese). The distinctions of an ethnic nature within the white population of the United States can be obtained only by inference, through association with the country of origin of the white foreign-born.

Consider, first, the incidence of mental disorders among Negroes, as measured by first admissions to all mental hospitals in New York State during 1949-1951, inclusive. During this period, Negroes had an average annual first admission rate of 223.5 per 100,000 population, compared with 123.4 for the white population. Since 81.4 per cent of Negroes in New York State on April 1, 1950 were living in New York City, compared with only 51.4 per cent of whites, comparisons were limited more properly to New York City, and rates were adjusted according to age and sex. On this basis, Negroes and whites had standardized rates of 340.4 and 173.6, respectively, a ratio of 1.96 to 1.

On the same basis, comparisons may be made for the significant groups of mental disorders. For general paresis, the standardized rates were 27.3 and 2.0 per 100,000 population for Negroes and whites, respectively, a ratio of 13.65 to 1. For the alcoholic psychoses, the standardized rates were 25.1 and 9.3, respectively, or an excess of Negroes in the ratio of 2.70 to 1.

Standardized rates for psychoses associated with advanced age were also higher for Negroes; thus, standardized rates for psychoses with cerebral arteriosclerosis were 192.8 and 81.5 for Negroes and whites, respectively, a ratio of 2.37 to 1. For senile brain disease, the corresponding rates were 88.9 and 65.3 for Negroes and whites, respectively, a ratio of 1.36 to 1. The most frequent disorder among both Negroes and whites was schizophrenia, but their respective rates were 111.8 and 49.1, or an excess of Negroes in the ratio of 2.28 to 1.

It should be noted, however, that although Negroes generally have higher rates of first admissions than whites, there are three exceptions. For involutional psychoses, the standardized rates were 27.6 for whites, but only 14.0 for Negroes. For manic-depressive psychoses, the standardized rates were 7.0 for whites and 1.6 for Negroes. Finally, the standardized rates of first admissions for psychoneuroses were 9.4 for whites and 3.2 for Negroes. It is possible that these three groups of mental disorders are actually less frequent among Negroes, but we cannot rule out the possibility that such disorders may be tolerated more readily in a Negro environment and thus call for fewer cases of hospitalization. However, this cannot affect the significance of the higher overall rate of first admissions among Negroes.

In addition to the connection between the high rate of first admissions and the generally unfavorable economic environment of Negroes, there is a further association with the high degree of mobility among Negroes, as shown by the fact that 64 per cent of the native-born non-whites, almost entirely Negroes, who were living in New York State on April 1, 1950, were born elsewhere in the United States, compared with only 16.7 per cent of the native-born white population.

The Jewish population of New York City was estimated at 2,035,000 in 1940, representing 29.2 per cent of the total white population. It is known that the great majority of this population were either born in eastern Europe, or were the offspring of such parentage. For all practical purposes, this group may be considered not only as a religious community, but also as an ethnic unity.

Those who have written on the ethnic distribution of mental disorders have concluded, for the most part, that the incidence of mental disorders is higher for Jews than for the general population. The data used in these studies were usually so inadequate that no proper conclusions could be drawn from them. In New York State, however, there are complete statistical records of admissions to all mental hospitals. From these, it was possible to sort out the Jewish first admissions from

New York City from 1939 to 1941. In comparison with the estimated Jewish population of New York City in 1940, it was possible to obtain average annual rates of first admissions, and to compare them with corresponding rates for white non-Jews.

The comparisons were made on the basis of age-adjusted rates. Jews of New York City had a standardized rate of 136.7 per 100,000 population, compared with 168.4 for non-Jews. The rate for non-Jewish whites was therefore in excess by 23 per cent.

The standardized rates for general paresis were 3.9 for Jews and 9.2 for non-Jews, the latter being in excess in the ratio of 1.35 to 1. Non-Jews, compared to Jews, had an excessive incidence of alcoholic psychoses, the standardized rates being 16.9 for non-Jews and 0.9 for Jews. Direct comparisons of standardized rates for psychoses with cerebral arteriosclerosis and senile brain disease were not possible, but within age limits set for these disorders, Jews had lower rates than non-Jews. Contrary to a customary belief, the standardized rates for schizophrenia did not differ significantly, being 39.0 for Jews and 38.8 for non-Jews. On the other hand, Jews had higher rates of manic-depressive psychoses and psychoneuroses.

Thus, though Jews clearly had a lower overall rate of first admissions than white non-Jews, there was a fundamental difference. The lower rate for Jews derived primarily from the groups of mental disorders classified as of organic origin, whereas, in general, Jews had higher rates for diseases of a functional order.

The white population of New York State is not classified officially according to ethnic origin. The federal census does include data for what is defined as foreign white stock. This refers to that portion of the white population living in New York State on April 1, 1950, born in a foreign country. It also includes the second generation of whites born in the United States whose parents were born in specified foreign countries. The largest totals of foreign-born whites (including second generation, United States-born) in New York State in 1950 were: Italy, 503,175; Russia (U.S.S.R.), 353,835; Germany, 270,661; Poland, 254,065; Ireland (Eire), 182,581. In some groups, history and geography combined to create a population that, for all practical purposes, is an ethnic unity.

Of the 182,581 Irish-born—141,723, or 77.6 per cent, were living in New York City. Of the native-born white population of New York State, only 51.3 per cent were living in New York City. Because of the

effect of a high degree of urbanization, in addition to the influence of varying age and sex proportions, the comparisons are best limited to New York City. Native-born whites had a standardized rate of 168.8 per 100,000. This was exceeded by all foreign-born whites, who had a rate of 183.3. The Irish-born, however, had a rate of 244.0, which exceeded that for any other foreign-born group. The Irish-born had a standardized rate of alcoholic psychoses of 38.1, compared with 11.3 for all native-born whites. In general, the Irish-born had higher rates than native-born whites for all major groups of mental disorders except general paresis and manic-depressive psychoses.

Rates of first admissions for second-generation Irish are in general less than corresponding rates for Irish-born, but they follow the pattern of being higher than rates for native-born whites. It may be concluded that the Irish stock has mental illness rates that are higher than rates for native-born whites and that also exceed the rates for other major foreign white stocks as defined by the Bureau of the Census.

In sharp contrast to the Irish, are the Italians, who constituted the largest foreign-born white stock in New York State on April 1, 1950. Because of the concentration of Italians in New York City, we shall limit the comparisons of standardized rates to the metropolis. Of all the major stocks defined by the Bureau of the Census, foreign-born Italians had the lowest rate of first admissions—138.3 per 100,000 compared to 183.3 for all foreign-born whites. Native-born whites had a rate of 168.8, which exceeded that for Italians in the ratio of 1.22 to 1. Compared to all other foreign-born groups, Italians had an exceptionally low rate for alcoholic psychoses, comparing favorably with similar rates for Jews. Only with respect to general paresis did Italians have relatively higher rates than all native-born whites or all foreign-born whites.

Second-generation Italians, like second-generation Irish, also had lower rates than the parental generation. The overall standardized rates for New York City were 118.1 for the second-generation Italians and 138.3 for the first generation. They also had lower rates than all native-born whites.

In summary, it is evident that there is great variation in the incidence of mental disorders among ethnic groups. The data do not permit one to state that the statistical difference arises from biological or social factors, or whether it is a combination of both. But it is clear that, in general, Negroes have a higher incidence than whites. Within the white

population there is a great spread between the low incidence among those of Italian origin and the high rate among those of Irish stock.

With minor exceptions, there has been an upward trend in rates of first admissions to mental hospitals in the United States. This has been shown decisively for New York State. There was a similar upward trend in prevalence (number of patients in residence) up to 1955. During 1956, however, the resident population in the New York State civil hospitals decreased by 463. There was a further decrease of 459 in 1957, followed by a very substantial decrease of 1,206 in 1958.

The resident population has continued to decrease and represents the first sustained downward trend in the history of New York State. Similar decreases in the number of mental patients under treatment have been recorded elsewhere in the United States and in Europe. The downward trend began abruptly and followed immediately after the introduction of current drug therapies. Because of this close association, it is felt that there is a true causal relation between the newer methods of treatment and the decrease in resident patients in the mental hospitals.

Resident patients in the New York State civil hospitals totaled 93,000 in 1955. They now total 86,500, and it is felt that by 1970 the total will probably be stabilized between 72,000 and 83,000. Reduction in population of New York State mental hospitals has been accompanied by other improvements, such as more tractable behavior of patients, leading to the possibility of more psychotherapy. We therefore have a favorable prospect for future developments in the treatment of patients with mental disorders.

MENTAL HEALTH

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What is mental health?

There are at present two schools of thought about the meaning of mental health. One, largely represented by the medical profession, finds it fruitful to think about mental health as the absence of mental disease. The second, largely represented by psychologists, the teaching profession, and psychoanalysts, regards mental health in positive terms as the presence of certain psychological characteristics. Each school has good reasons for its approach. To regard mental health as the absence of mental disease is in keeping with the traditional task of the medical profession to help and cure. So many persons suffer from mental illness or emotional disturbance that the task of dealing with their problems appears overwhelmingly important, even without adding the complication of asking whether those who are free from disabilities are thereby also free to strive for a full and satisfying life.

This last question is the major concern of the second school of thought about mental health. To think of it in positive terms avoids one major problem in the first approach, that there is no general agreement on what constitutes mental disorder. It is easy enough to recognize severe forms of mental illness; but with less severe disturbances it is not easy to say whether a person is actually ill or not. And where socially disapproved behavior is concerned, for example, in the current controversy about whether or not certain crimes should be regarded as the result of mental disturbances, the fact that no general definition of mental illness is available makes the debate hopelessly confused. To regard mental health as the presence of certain qualities avoids this particular difficulty. It also has the advantage of setting specific and concrete aims for mental health education. This article deals with questions of positive mental health. Those who prefer to think of mental health as the condition of not being ill, will find other articles in this encyclopedia more relevant.

Is mental health a scientific concept?

No, it is not, in the strict sense of science. Health and disease, whether physical or mental, are convenient labels attached to specific

forms of functioning which support the fundamental value of survival of the species, or other values derived from it. Science is not concerned with desirable or undesirable, good or bad, healthy or sick, ways of functioning; it is concerned with understanding and with predicting—that is, with specifying the conditions under which one event is more probable than another—all types of functioning without regard for human values. In physical health and disease, the underlying value is so universally accepted that its tacit assumption presents no particular problem. In mental health and disease this is not the case. To single out any form of behavior as mentally healthy is an act of choice and values. To study this form of behavior in its origin and consequences is a legitimate task of science.

What forms of behavior are currently regarded as mentally healthy?

There exists a bewildering variety of definitions about positive mental health. Yet, however varied the formulations, basically they can be reduced to two major areas: the relation of an individual to himself and the relation of an individual to the world around him. These two areas are, of course, closely related. Many psychologists have demonstrated in their studies that a person cannot have healthy relations to others unless he has a healthy relation to himself. And, vice versa, the healthy relation to oneself is a result of one's early relations to others.

But the distinction is nevertheless meaningful; for it requires different types of observation and knowledge of another person if one is to look at his relation to himself as an indication of mental health, or if one is to look at his relation to the surrounding world for the same purpose.

What is a healthy self?

Here three major ideas have been propounded. First, a person is called mentally healthy when he understands himself and his own motivation, his drives, wishes, and desires. This self-knowledge is regarded as healthy when it leads a person to accept himself, recognizing his liabilities and assets, his past behavior as well as his present behavior. Of course, many persons think they know themselves, but not all who think so actually do. This is why it has been stipulated that a healthy self-image must also be a correct one. Now it is, of course, not easy to decide whether a self-image is correct. It may be idealized or debased, and it may be in conflict with what intimate associates of a person think

about him. Many psychological conflicts in family life, for example, arise because a member of the family sees himself as being different from the way other members of the family see him. A scientifically trained expert is often in a better position than close relatives to decide whether an individual's self-image is correct. However, a correct self-image, based on self-acceptance and self-knowledge can still have qualities which are regarded as unhealthy by many; it can be unstable and shifting with the situation in which a person finds himself. This is why several authors require that the individual possess a more or less stable sense of inner identity to be called mentally healthy.

The second major idea proposed about a healthy self, views the person not at any one moment but from a longtime perspective embracing his entire life-span to the date of assessment. It has to do with what a person makes of himself, and is often described as self-realization, self-actualization, growth, or becoming. The idea appeals to many because it recognizes that psychological development consists of a process of increasing differentiation in becoming what one potentially is. This idea is often used to describe a general principle governing the development of every living organism, and in that sense few will take exception to it.

When self-actualization is taken as a criterion of mental health, however, problems involving value judgments and philosophical convictions do arise. Is the self-actualization of the drives which push murderers into action to be regarded as mentally healthy? Or, if this is not self-actualization, how can it be distinguished from it? Those who believe that human beings are innately good will find self-actualization a satisfying criterion of mental health. Those who believe the opposite, as well as those who wish to avoid either position, will probably be more hesitant in its use.

The third idea relevant to the healthy self is concerned with a process called integration of a personality. Integration is a term which presupposes that there are several structural units in a personality—in psychoanalytic terms, for example, the ego, id, and superego—which can, but need not, achieve a certain balance. But the term is often also used to indicate whether a person's conscious outlook on life is unified or contains contradictory elements. In either sense, the balance between the various units is regarded as flexible, not as a rigid equilibrium. What is meant by a flexible balance is, perhaps, best illustrated by thinking of a person under some considerable stress. Where the balance is rigid, i.e., unhealthy, such a person will appear not to respond at all to the

stress; however, after a certain degree of stress, he may well go to pieces completely. Where the balance is flexible, i.e., healthy, response to stress will appear sooner, say at a point where readjustments are still possible. The most frequent response to stress is some degree of anxiety which serves as a warning signal to mobilize internal or external defenses. Thus, in contrast to much popular belief, *anxiety of some kind is not a sign of ill health but a sign of health*. It is, of course, true that many forms of mental disease are characterized by states of intense anxiety with which the patient cannot cope. The distinction between anxiety as a symptom of disease and anxiety as a healthy signal to mobilize defenses is best left to the expert in any individual case.

What are healthy relations to the external world?

Here again, three major areas have been suggested as criteria for positive mental health: a person's autonomy, his perception of the world, and his efforts at environmental mastery.

Autonomy is frequently interpreted as the ability to make decisions based on internalized standards rather than on expediency in terms of external pressures. Sometimes, it is not the decision making, but the implementation of such autonomous decisions in independent behavior which is called mentally healthy. This criterion has, however, a peculiar difficulty of its own: too much autonomy—that is, behavior completely independent of external influences or regulated by idiosyncratic individual standards—is found probably more often in the mentally ill than in people who can live outside mental institutions. That is why this criterion needs further specification to be useful. Autonomy can certainly not be regarded as mentally healthy if manifested in every action or decision. This is good common sense; but the step beyond common sense into delineating when autonomy is mentally healthy and when not, has not yet been taken.

Perception of external objects and events is called a criterion of mental health when such perception is guided by clues in the outside world, and not when it is the result of wishful thinking or distortion of external clues. When we perceive familiar objects in the world around us, most of us have amazingly well-developed mechanisms to achieve a correct image; looking from a high building into a busy street, for example, we see men and cars not of toy-size as they actually impinge on the visual nerves, but in their true size. There are many ways in which we learn to correct in perception for possible distortion caused by lack of clarity, or by darkness, or distance, when we look at familiar

objects. But matters on which we have less experience and, therefore, less chances to assess the accuracy of our perceptions are more easily distorted. One and the same person can be perceived by one man as a genius, by another as a lunatic. One and the same social situation can be experienced by one participant as loaded with tension, by another as relaxed. Since in these cases of complex social perception universal standards for verification are not available, who is to be the judge of the accuracy of a percept? It is because of this fundamental difficulty in assessing the degree of correctness in social perception that the emphasis on the relations of percept to cues in the external world is so important, when perception is used as a criterion of mental health.

Finally, there is the idea of environmental mastery. Under this broad title many types of behavior are subsumed which have in common that they all manifest themselves in a person's everyday life. In mental health literature the idea of environmental mastery is treated at varying levels of concreteness. Ordering them, roughly speaking, from most to least concrete, the following aspects have been singled out: the ability to love; adequacy in love, work, and play; adequacy in interpersonal relations; efficiency in meeting situational requirements; capacity for adjustment and adaptation; and efficiency in problem solving.

The idea that ability to love presents a criterion of positive mental health has occasionally been given a narrow meaning as the ability to experience orgasm in heterosexual relations. While there can be no doubt that the capacity for sexual enjoyment is often a sensitive indicator of a person's mental health, a too narrowly concrete emphasis on orgasm only, without regard for the quality of interpersonal relations in the sexual act is nowadays often regarded as an unsuitable criterion. Presumably a sex murderer has the capacity for orgasm, albeit only in peculiar circumstances. A more appropriate formulation, therefore, is to assume that the inability to experience an orgasm is probably a sign of a disturbance; the mere ability to have such experience is in itself no sufficient indication for positive mental health.

One extension of this criterion is the stipulation that the healthy individual must be adequate in love, work, and play; or the idea that interpersonal relations (including heterosexual ones) are to be scrutinized for evidence of positive mental health. In this broader, and less specific sense, adequacy in relation to others is often not limited to positive aspects but includes the idea that a healthy person is not afraid to be reasonably aggressive when the occasion demands it.

Meeting situational requirements and adaptation or adjustment are

occasionally open to an interpretation which assumes that the healthy individual accepts passively and unquestioningly whatever life brings. Indeed, the mental health movement has often been criticized as advocating submissiveness to circumstances, or as being a moral injunction disguised in pseudoscientific terms to maintain the social status quo. It has been accused of trying to induce people to want what they get at the expense of encouraging them to get what they want. Undoubtedly some aspects of the mental health movement in its early stages have justified such criticism. However, modern formulations of these two aspects of environmental mastery, as a rule, are based on the assumption that the human organism possesses the capacity to modify his environment as well as to be modified by it. Particularly, adaptation to reality is thought of as an active effort by an individual to choose or create such environments as are most suitable to his inner needs.

Finally, there is the idea that problem-solving behavior provides a clue to a person's degree of positive mental health. Note that the emphasis is on solving, not on the solution. To discover a solution to any of life's problems may be the result of luck and chance; to engage in appropriate ways of problem solving will lead to a solution only if environmental circumstances are favorable.

Which of these various concepts of mental health is most useful?

It is impossible to answer this question in general terms, for the answer depends in part on the purpose for which a mental health criterion is sought, in part on the qualifications of the person seeking to apply it, and in part on more knowledge than we have to date on the antecedents and consequences of each of these mental health criteria in a person's life. The most general thing that can be said about all these concepts is that if suitable ways of assessing a person's state of mind are available, it probably does not matter too much which of them is selected.

Does this mean that the concepts are not fundamentally different from each other?

At least for some of these concepts this is right. On a theoretical basis, there is much reason to expect that several of these mental health ideas present only different manifestations of one and the same state of affairs; for example, one expects that an integrated personality will also excel in environmental mastery, whatever aspect of it is selected, or that a person capable of perceiving his environment free from dis-

tortions will also have an adequate self-image. But these examples demonstrate, by the same token, why the differentiation is nevertheless meaningful: integration may be a more fundamental aspect of the personality than appropriate forms of problem solving. To establish the former requires different observations, and probably much more time than to establish the latter. However, much more knowledge than we possess at this moment is required before we can say with certainty how much overlap there is between the various suggested criteria of positive mental health.

On the other hand, some of the criteria probably do tap different aspects of human behavior. It has been suggested, for example, that in different situations of stress, undistorted perceptions of the situation will lead to abandoning appropriate problem-solving behavior, and vice versa.

Why is happiness excluded from the list of criteria?

Happiness has indeed often been suggested as a criterion for positive mental health under a variety of additional terms, such as contentment, well-being, freedom from conflict, etc. To accept happiness as a criterion is particularly suggestive because of its contrast to the utter unhappiness which so often accompanies the obvious absence of mental health. The difficulty of the idea concerns the dependence of the state of happiness on external factors which are outside the control of the individual whose mental health is under scrutiny. It is easy to imagine situations in which no person judged mentally healthy by every other criterion would feel happy. One reformulation therefore suggests that the criterion means not the state of being happy, but the disposition to be so when circumstances are appropriate. This is a more tenable proposition, but when its context is examined, it shows so much overlap either with self-acceptance, integration, or attempts at environmental mastery, that there remains little reason to regard it separately.

What about normality? Is this not a sufficient criterion for positive mental health?

Normality carries at least two distinct meanings. First, we call behavior normal if it is frequently manifested, that is, if it corresponds to a statistical norm. This connotation would lead one to regard average behavior as healthy, and deviations as unhealthy. As stated before, health is a term implying a value—it is a good and desirable form of behavior. Most people who are concerned with problems of mental

health are reluctant to commit themselves to the value that the majority is always right, or that deviations from the average are always a sign of undesirable functioning. But even apart from these value considerations, the statistical notion of normality is rather empty. For unless mentally healthy people are supposed to resemble each other like one egg the other, not every type of behavior is surely meant to be included in a definition of mental health. However, there is no indication in the statistical meaning of the term in what respect the average person is to set the standard for normality. (See *Neurosis and Normality*)

The term has a second connotation: some persons use it to mean a normative standard of how people ought to behave. In that sense normality is nothing but a synonym for mental health, and requires exactly the same elucidation.

Are the major criteria for mental health suitable for each age-group?

No. Several of the criteria are obviously applicable only to adults. A stable, comprehensive, and correct self-image, for example, cannot be expected in children or young people. Adolescence is the period in life that is generally assumed to bring with it an upheaval of the self-image which changes from day to day; virtually no adolescent could be called mentally healthy by this yardstick.

Among the criteria discussed there are three that have meaning for every age-group beyond infancy: perception of reality relatively free from need-distortion, meeting the requirements of the situation, and problem solving. Adaptation in the sense of actively modifying the human environment to suit one's own needs is hardly ever open to young children in our civilization. Within the limits set by family and school life which the child is compelled to accept, adaptation has little scope to display itself.

Are the major criteria for mental health equally suitable for men and women?

There is no reason to believe that a person's attitude to himself or herself—healthy self-image, self-realization, or integration of personality—is linked to biological or psychological differences between men and women. The same is probably true for perception free from need-distortion. Autonomy is, perhaps, less appropriate as a criterion of mental health for women than for men in a society in which the wife's obedience to her husband is widely regarded as a virtue. Not that all wives demonstrate this virtue, but as long as such lack of autonomy

is a culturally approved value, many women will, consciously or unconsciously, refrain from practicing autonomy.

Environmental mastery, as a summary category, has the connotation of being associated with a man's rather than a woman's role in society. But this is easily shown to be due to linguistic usage only. The more concrete ideas described under this term—ability to love, work, and play; adequacy in interpersonal relations; meeting situational requirements; adaptation and adjustment; problem solving—are as readily applied to women as to men.

Are the major criteria for mental health equally suitable for all societies?

The criteria in themselves can be applied to every human being, wherever he lives. But this does not imply that they would be singled out as characteristics of mental health in every society. Where the freedom of the individual is not highly valued, the relation of a person to himself will probably not be singled out in this manner. There are some societies in which religious beliefs about losing oneself—the Nirvana idea—rather than finding oneself dominate. It is unlikely that the same type of self-image would be regarded as mentally healthy in such a society as in ours. Actually, there is little evidence for thinking that nonindustrialized societies are as much concerned with questions of mental health as our society.

What is known about the level of mental health of the population measured by any of these criteria?

There exists one nationwide survey, made in the late 1950's, of some mental health measures of the general population in the United States (*Americans View Their Mental Health* by G. Gurin, J. Veroff, S. Feld). However, it is in the nature of things that these measures are meaningful only when one group in the population is compared to another, for there exists no absolute yardstick by which the maximum amount of, say, integration of personality or adaptation could be assessed. All that is possible is to say that old persons more than young ones, men more than women, or any other comparable groups manifest any one of the criteria. The study investigated among other matters the self-image of the population, and found that women tend to be more negative in their self-image but also more aware of it than men. Men are more self-critical with regard to achievement and success; women more with regard to their own personality and their relations

with others. Older persons accept themselves more readily than younger ones. The more highly educated a person is, the greater is his self-criticism and his self-awareness.

One other measure from this study is of interest here because it refers to the criterion of self-actualization which was assessed in the survey with regard to the meaning of work. It was found that persons with lower education not only obtain less satisfaction from their jobs but also experience less distress in work. These findings are convincingly interpreted as indicating that the criterion of self-actualization is one which will assign a better score on mental health to the more highly educated, higher status group of the population. This demonstrates clearly that self-actualization is based on middle-class values. Since all mental health notions have implicit value biases, this in itself does not speak for or against the criterion. Studies such as the one quoted here help to make explicit which values are involved. More research is needed before similar statements can be made about the other criteria in this respect.

How reliable are the methods by which mental health criteria are assessed?

In the human sciences all measurements are still crude approximations to a state of affairs rather than accurate indicators. The study mentioned before was based on interviews; it follows that the data refer only to those aspects of the human experience which people are aware of and willing to communicate to a skilled interviewer. There exist other techniques—clinical study, prolonged observation, projective techniques, etc.—which have greater scope and depth than an interview. But these methods require much more time than interviewing and can only be used by highly skilled experts. At the present moment their application to a nationwide sample is impossible. They are being used, however, with individuals and small groups. Extensive and intensive methods of inquiry must supplement each other to extend, step by step, our knowledge in this area.

Two of the major criteria, perception and problem solving, are highly developed subjects within psychology, and sophisticated methods exist to assess how people function in this respect. This work has been carried out largely within experimental psychology, unconcerned with the place of these functions in the sphere of positive mental health. However, it will not be too difficult to apply the knowledge and methods thus collected to the selective purpose of mental health research.

What is known about the acquisition of mental health?

Very little specifically, and a great amount on a more general level. On the more general level, the question is tantamount to asking what is known about the factors which influence personality development. Notwithstanding current controversies in the field, there is a growing body of agreement on some basic factors.

First, the old controversy which assumed that either heredity or environment largely accounted for personality development is being resolved in the assumption that both factors are inextricably involved in every living organism. Heredity sets the broad potential, and environmental influences provide the occasion for learning how to develop, modify, or suppress this potential.

Second, most experts agree that early environmental influences are more powerful factors in personality development than those which are met after childhood.

Third, it follows that the earliest environment, that is, the family, must be regarded as the strongest factor in determining the direction of personality development.

Fourth, this is not to say that gross external environmental factors, such as national culture or social class, wealth or poverty, are unrelated to personality development. However, they do not directly impinge on a child in his formative years, but only indirectly to the extent that the adults in his immediate surroundings transmit these influences to the child in their attitude and behavior.

On the more specific level, all too little is known about the factors which lead to a healthy self-image or healthy relations to the external world. One reason for this is that until very recently the development of children had been studied by concentrating on the child only, at best in relation to his mother. The family as a unit in which the position of every person vis-à-vis the others and himself is regarded as an integral part of the early environment is only now emerging as an important focus for understanding the qualities of the early environment.

In particular, the emerging self-image and the child's ability to perceive correctly how other people feel will be influenced by the complex network of relationships which exists in every family. Many parents are in the habit of attributing to each of their children specific permanent characteristics which may or may not agree with the way a child sees himself. Where there is disagreement between these mutual perceptions, a child will hardly develop a sense of stable iden-

tity; he may come to distrust his own inner experiences and force himself to adopt his parents' view so much, that he will not be able to see the world from his own position in life.

In view of the importance of family life for the development of the child's personality, can schoolteachers still have a significant influence on his mental health?

Again, not very much is known about this in a systematic way, but the fact that early childhood is important must not be taken to mean that the personality is rigidly established by the time a child enters school. Changes can occur until late in life, but the older a child, the more difficult it is to encourage and promote a desired change. At school age, a teacher can still achieve much, if she has the psychological insight to know what is needed, and the time and skill to adjust her educational efforts to the needs of individual children.

Is mental health, assessed by any of the criteria mentioned, compatible with genius?

Yes. While it is true that many persons of extraordinary gifts have suffered from mental disturbance, there are many more who have apparently been healthy. However, it is quite possible that a genius will develop in a one-sided fashion, for example, that he will live for his art or science only, without meeting the requirements of a situation or demonstrating the ability to love, being tormented by an unfavorable self-image without stability or integration. When parents or teachers discover in their children extraordinary gifts, they may, therefore, be in a conflict between encouraging these gifts—perhaps at the expense of mental health; or encouraging mental health—perhaps at the expense of extraordinary achievements. While this conflict need not appear in all cases, it can appear in some. There is no easy way out of the dilemma. Great achievements of the human spirit and mental health are both positive values; where they are incompatible the choice has to be made in each individual case.

What is the relation of mental illness to the criteria of positive mental health?

This is a highly controversial question. Most psychiatrists assume that mental health and mental ill health are directly opposed to each other. But some psychiatrists report that their sick patients show considerable variation in the degree with which they meet some of the

criteria of positive mental health. Some patients have hardly any insight into their own self, while others have considerable insight into matters which are often not accessible to consciousness among the so-called "normal" population. Psychiatrists concerned with positive mental health speak of differences in the "health potential" of their sick patients.

People who are mentally deficient are a good example for the justification of distinguishing mental illness from low mental health. A mentally deficient person can be, but need not and often is not, mentally ill by the judgment of most psychiatrists. But it is fair to say that he will be found low in most of the aspects of positive mental health. A certain amount of intelligence seems to be required to achieve a healthy relation either to oneself or to one's environment.

If low positive mental health is not the same as mental disease, by the same token mental disease need not imply that there are no traces of positive mental health. This is not just a disagreement about terms. If the idea is taken seriously, a search for signs of positive mental health in mental patients may lead to important discoveries about promising approaches to a cure of disease. It is quite possible that the signs of positive mental health in mental patients will be rudimentary only; nevertheless, they may serve as levers for therapeutic efforts.

MENTAL HEALTH IN COLLEGE

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What are the aims of mental health programs in colleges?

Both immediate and long-term goals are involved. Students in distress from emotional conflicts should be treated or helped in obtaining appropriate therapy. All teachers should be helped to do what a few excellent teachers have always been able to do, namely, to excite students to perform at their highest level of ability with enjoyment in their work. Both teachers and students should be aided in understanding themselves in such a way so as steadily to increase the conscious control of their behavior with a subsequent lessening of domination by primitive and unregulated emotional drives derived from unconscious sources. As knowledge of the emotional aspects of learning increases, one expects to see a parallel improvement in educational methods, leading to a resolution of the increasing numbers of students' emotional problems. It should not be necessary for students, or anyone else, to have to wait until their difficulties become so exaggerated as to require professional help from psychologists or psychiatrists.

Students almost invariably do well when they are inherently curious, when they feel that what they are doing has meaning and purpose for them, and when they are not unduly burdened by emotional conflict. A good mental health program should discover and help correct those emotional conditions on the campus that impede learning. It is likewise desirable to aid both students and faculty members in recognizing those conditions in society that tend to bring about severe and disabling emotional disturbances.

What is the history of mental health programs in colleges?

For more than a hundred years an occasional college president has publicly deplored the poor emotional state and the high but unexplained dropout rate of his students. Only in the last half century have any concerted attempts been made to do something about the situation.

Stewart Paton of Princeton University was the first person on record

who called attention to the need for the study of personality development among college students. In 1910 he set up a clinic at Princeton to give aid to students with emotional problems, and this became very popular. Early work in this field was also begun by Smiley Blanton at the University of Wisconsin in 1914, Karl Menninger at Washburn College in 1919, H. M. Kearns at the United States Military Academy at West Point in 1920, Arthur Ruggles at Dartmouth and Yale in 1921 and 1923, Austen Fox Riggs at Vassar College in 1923 and later at Williams College. The work of Clements C. Fry of Yale from 1926 to 1955 has been of greater importance than that of any other single individual. His book (with Edna Rostov), *Mental Health in College*, was the first major work in the field. Among the most important mental health programs in American universities are those of the Universities of California at Berkeley and Los Angeles; the Universities of Minnesota, Chicago, and Nebraska; Yale, Harvard, and Cornell universities; Vassar College and Massachusetts Institute of Technology.

The first international conference on student mental health was held at Princeton, New Jersey, in 1956, with representatives of ten countries. A book resulting from this conference, *Student Mental Health* by Daniel H. Funkenstein, contains much basic material which should be familiar to all college mental health workers. A conference of European experts in student mental health was held in Switzerland in 1961 with more than a dozen countries represented.

What are the major emotional or psychiatric problems with which colleges deal?

College students develop psychiatric problems in the same manner and from the same causes as all other persons. Many people unfamiliar with colleges are surprised that students should have so many emotional conflicts.

The most common outward sign of inner emotional conflict is anxiety in all its various forms. Students may become tense, irritable, apathetic, self-centered, and unable to sleep restfully. They develop particular concern about their adequacy in the roles in which they visualize themselves cast in their social setting. Their struggle over the question of their identity, in the eyes of others as well as themselves, is a major one.

Physical symptoms referable to the various organs of the body, the so-called psychosomatic symptoms, are quite common.

Panic preceding or during examinations is a regular occurrence, and

every college health service can expect several such episodes each year.

Feelings of depression are also very common. Many of the students so affected find it impossible to sustain interest in their work. A typical student with mild depression said, "I can't make myself want to work." Some of them fail academically, drop out of college for a year or more, and then return doing excellent work. Many famous people have suffered such depressive illness in their youth, John Stuart Mill being a prominent one. A few depressed students become suicidal. Although reliable figures do not exist, informal investigation by the writer suggests that most colleges have about one suicide for every 8,000 to 10,000 "student years" of enrollment.

Schizophrenia occurs with the same approximate frequency as in the general population. Many students who experience acute psychotic episodes are capable of recovering and resuming their college work if treated intensively and properly.

Character disorders with their accompanying behavior problems occur with lesser frequency than in the upper grades of elementary school or high school, but there are always enough to form a serious problem.

Experimentation with a wide variety of drugs, ranging all the way from the popular caffeine preparations and Benzedrine to mescaline and marihuana, is common enough among the emotionally unstable to cause all college officials to be constantly alert to the possibility of their use.

Practically all college psychiatrists are in agreement with the estimate that about 10 per cent of all college students need some professional help each year in the resolution of their emotional disturbances.

What are the causes of these disturbances?

Disturbances in interpersonal relations prior to college entrance are of great frequency and underlie many of the problems seen during the college years. The most important of these are with parents. A student may feel that his parents make all his choices for him, try to manipulate his behavior and his choices of courses and career, or even choose his associates. Emotional conflict between the parents has a particularly devastating effect on the feelings of security of a son or daughter. Marked discrepancies between values upheld by parents and the home community and those in favor in the college or university may cause serious uneasiness. Sexual questions are of immense concern at this age. Problems in the sexual field, associated with dilemmas about courses and career choice, are partial problems feeding

the student's more generalized conflict over who he is and what he is to become. Erik H. Erikson in his books, *Childhood and Society* and *Identity and the Life Cycle*, has described such quandaries under the term "identity crises," and his writings have been very helpful to all workers in the area of late adolescent and early adult development.

Students who have inadequate or improper models to imitate in their younger formative years are thereby made more vulnerable to emotional stresses later. Absent or inconsistent discipline is a powerful disruptive force tending to weaken personality integration. Parents and other significant adults who exhibit emotional coldness and rigidity, intolerance, improper discrimination against persons for qualities over which they have no control, and who fail to teach proper knowledge and attitudes about body functions are adding significantly to the possibilities that the young people exposed to them will suffer inhibiting emotional disturbances. Any combination of circumstances that makes children feel isolated, rejected, or not respected as separate persons will add to the probabilities that they will need help in college, if not before that age.

Are these problems different in the various kinds of colleges?

Variations between large and small colleges, and between rural and urban institutions are relatively slight. Culturally determined attitudes, at times, cause an apparent difference. A student in a small college with little or no sophistication regarding psychiatric matters might have a very serious set of problems with clear-cut symptoms and might not be thought of as being ill, either by his associates or by his own estimate. In a community with widespread awareness of the nature of emotional disturbances, a student in emotional conflict will be recognized as being in need of help much more quickly than in a less sophisticated college.

In the writer's experience, several colleges have been led to the recognition of the seriousness and scope of the emotional problems of their students only after some singularly dramatic event, such as a murder or a series of suicides, has forced the responsible authorities to look at the evidence easily available all around them.

What percentage of colleges have mental health programs? Is this rate changing?

In the *Bulletin of the Menninger Clinic* (Vol. 20, 1956), the article, "Mental Health Programs in American Colleges and Universi-

ties" by Sigmund Gundle and Alan M. Kraft, reports on two surveys conducted during the past decade, which indicate that about one hundred colleges (11 per cent) in the United States have some kind of organized mental health program. This probably represents about a one hundred per cent increase over the situation two decades earlier. The rate of change during the last decade has been rather slow.

How many students are served by these programs?

No reliable figures exist to answer this question. Since most mental health programs have been organized in the larger institutions, it seems reasonable to suppose that about one-third of all college students, or 1,300,000, are enrolled in colleges with such programs. Since most services can actually see about 5 per cent of the students enrolled, the number of students with direct contact would be about 65,000. This figure impresses the writer as still being higher than is probably the case.

Experience at Harvard University, with its comparatively large psychiatric service, is illustrative but not typical. During the years 1958 to 1961 slightly more than 1,000 students (7 per cent of the enrollment) were seen by psychiatrists each year. It was well known that many students consulted psychiatrists privately, but the percentage was not known.

How many psychiatrists and other mental health personnel are there in these programs? What are their specialties?

A 1928 survey cited by Dana L. Farnsworth in *Mental Health in College and University* indicated that about 16 colleges had some type of organized mental hygiene activity. Another in 1947 showed that about 550 psychiatrists did at least occasional consulting for colleges of whom 30 spent their full time in college psychiatry and 63 were engaged on a regular part-time basis. The last reported survey in 1956 by Gundle and Kraft, mentioned above, indicated that about one hundred colleges had organized mental health programs. Another survey of total college health facilities at about the same time showed that at least 125 colleges had psychologists on their staffs specifically to do counseling. From the informal sources of information available to the writer, the number of full-time psychiatrists working in colleges in the United States certainly does not exceed 45 at present, and may be slightly less.

Psychologists and psychiatrists constitute the great majority of mental health workers in American colleges and universities, though there are

a very few social workers also occupied in such schools. One major service is directed by a social worker.

Are other college personnel involved in the programs?

Anyone who does counseling in any form could be said to be involved in promoting mental health. Counseling programs are very intensive and effective in many colleges and universities. Training centers have been established and have been functioning for many years in developing professionally trained counselors. Distinguished work in the field has been done at Columbia University and at the Universities of Minnesota, Illinois, and Wisconsin, as well as several other centers. In fact, the entrance of psychiatrists into college mental health work has been relatively late, and their influence and number are small compared with that of counselors with basic psychological orientation.

Ideally, all persons in a college who have counseling relations with students should have easy communication channels with psychiatrists of the student health services in order that the possibility of overlooking serious mental illness be kept at a minimum.

Do these figures represent an adequate overall program?

They do not. In fact, the problem of promoting the mental health of college students in the United States is being met by college authorities with insufficient finances, inadequate understanding, and little or no enthusiasm in all but a very few institutions.

How does the individual come into contact with the program? Is there a fee?

In those colleges with adequate psychiatric services, the student who desires help has only to ask for a consultation with a psychiatrist or psychologist and he will get it, almost at once if his need is urgent, or within a few days if there is no hurry. In the majority of institutions a variety of counselors are available for special vocational or academic problems, but psychiatric interviews are obtained only by special arrangements between the student, the counselor or dean who may be particularly interested in him, and the director of the health service.

Ordinarily there is no fee for emergency, diagnostic, or brief psychotherapeutic sessions. Some colleges impose a modest fee after a certain number of interviews, five to ten being common limits, but

more often the student is referred for private treatment if this is possible.

What kinds of treatment are available in colleges?

Available treatment ranges all the way from none at all in the majority of colleges to a maximum of twenty to thirty hours of psychotherapy for scholarship students in schools with large mental health programs. No college in the United States or Canada offers definitive psychiatric treatment as part of its health service.

The experience of Harvard University may be representative of the large universities with reasonably adequate health services containing mental health programs. During the years 1959-1960 and 1960-1961 slightly more than 1,000 students (from an enrollment of 13,000) were seen for about 5,700 interviews each year. Whereas many students were seen only one to three times, a considerable number (about forty) were seen from ten to twenty times and a few for even more than that. Any student who reported to the psychiatric service with a deep-seated or long-continued emotional problem requiring prolonged psychotherapy was referred, if possible, to a private psychiatrist or a public psychiatric clinic. An indefinite number of other students were seen by private psychiatrists. This suggests that even the most affluent universities cannot meet the full demand for psychiatric treatment from their students without charging unacceptably high health fees.

Psychotherapy as practiced in most colleges is usually brief and devoted to the development of sufficient insight to enable the student to solve his own problems more effectively. Psychoanalysis is not done because of time, expense, and other factors. Pharmacotherapy has a limited, though at times, important place. Treatment of the severe illnesses follows the procedures of the hospitals to which the patients are admitted.

What is the principal purpose of treatment?

The principal purpose of treatment is the resolution of emotional conflict and the removal of whatever impediments to effective performance students may be experiencing.

Short-term psychotherapy is peculiarly effective in people of the college age-group. Older persons have more firmly set patterns of thinking and behavior than do the young adults, and whatever forms their neurotic defenses may take, their resolution is accomplished with greater difficulty than in the people of college age. Students are "fresh

from their symptoms," they are accustomed to intense and critical examination of all aspects of subjects under study, and these factors combine to make them a very favorable group for intensive but brief psychotherapy. They are in a psychological and biological phase in which growth and change are natural and usual events. They are able to profit not only from appropriate reassurance, supportive therapy, and environmental manipulation, but also quite often from interpretation of unconscious motives for their behavior.

Definitive psychotherapy involving radical personality reorganization is beyond the scope of college mental health programs. Treatment goals are not conceived in terms of patching up a person so that he may go along as he did before. Instead, they are envisaged as brief but influential examinations of ineffective or inappropriate methods of adaptation designed to enable the patient to handle himself with greater effectiveness and satisfaction in later periods of stress. Psychiatric treatment in college should not result in a student feeling that he must type himself thereafter as a former patient. Rather, such treatment constitutes a form of personal tutoring in an aspect of personal growth and development commonly ignored or neglected in routine and planned educational curricula for college students.

What is the record of success of treatment?

Like so many of the other important questions concerning psychiatry and mental health, this one cannot be answered definitely. The staff members of the larger psychiatric services, with which the writer is familiar, estimate that about two-thirds of their patients achieve obvious benefit. Certainly very few, if any, are harmed by treatment, and it is possible that late beneficial effects may result from seemingly fruitless attempts at therapy. A research program designed to determine the results of therapy in some of the larger centers would be very desirable.

What percentage of individuals continue care after leaving college?

Again, there are no statistics to aid us. The number is probably not greater than 5 to 10 per cent of those who seek aid from their college psychiatric services.

Are there organizations in the community which are concerned with mental health in college?

None that give more than a little moral encouragement to the idea.

What steps have colleges taken for the prevention of emotional and psychiatric problems among students? Have any changes been made for this purpose in college routines, facilities, or curricula?

The honest answer to this question must be that nothing of significance has been done along these lines. The various national and regional organizations of deans and counselors have shown considerable interest in preventive activities, even to the point of having speakers and seminars on the subject. College presidents are greatly concerned over the epidemics of emotional instability in their students and in their faculties, but most of them do not know how to begin an effective program of prevention. Vigorous and imaginative approaches are needed, with participation by a variety of interested parties as suggested later on.

Do secondary schools have any mental health programs which relate to college mental health programs?

Some of the older private preparatory schools have psychiatric and psychological consultants in their health services. There are many counselors in secondary schools of all kinds, but a high percentage of them plan their major emphasis on choice of course or career, or selecting a college, with relatively little emphasis on consideration of emotional aspects of learning and adaptation. The in-service training of such counselors is a much neglected task awaiting educational authorities.

Could more extensive psychological testing help to avert the occurrence of emotional and psychiatric problems in college?

Probably not, in the present state of our knowledge. The undoubted predictive value of a few tests must be weighed against the mechanical, financial, and psychological obstacles to mass testing of all entrants to college. The best tests are given individually and cannot be effectively administered with large groups. Competent psychologists trained in such testing are too few in number. Testing that would lead to diagnoses for which no therapy were available would be of little help and might create grave new problems.

It is true, however, that the availability to the psychiatrist of a competent test psychologist can greatly facilitate the short-term treatment usual in college clinics, by rapidly clarifying underlying aspects of emotional situations. (See *Psychodiagnostic and Personality Testing*)

What part of the college mental health program is concerned with the prevention of emotional and psychiatric problems in the student after he has finished his education?

Any college mental health program should be as much educational as therapeutic. Working with teachers, counselors, and students about the emotional problems of others tends to have a cumulative beneficial effect. About one-half the efforts of college mental health workers should be essentially preventive in nature.

Do studies of mental health in college serve the purposes of general research into human behavior?

They certainly do. Such studies give valuable information regarding strengths and weaknesses in family life, factors affecting personality development in the early years, modes of coping with the tasks of the late adolescent and early adult periods, and early signs of later serious mental illness. Since college students will form so influential a part of society in a relatively short time after graduation, it would be difficult to think of any group whose motivations, backgrounds, attitudes, and aspirations would be more worthy of study.

A worthwhile series of studies at Yale University, *Psychosocial Problems of College Men* by Bryant M. Wedge, has recently been published. It would be desirable not only for people working in this field to make use of the data they have in hand, but also to attract to the study research workers whose interests lie in pure science.

Based on current studies, what might be predicted about the methods and scope of mental health programs in colleges in the near future?

There appears to be a gradually increasing interest in mental health programs in American colleges, but progress is slow because of the lack of trained psychiatrists who can be attracted to work in educational institutions. A frequent and typical situation is that in which the administration and faculty of a given college study their needs, find that a mental health program is needed, provide money in their budget for a psychiatrist, then set about finding one, with no success. Colleges located in urban centers have a much greater probability of finding a suitable psychiatrist than those in smaller cities and towns, as is pointed out in Dana L. Farnsworth's article, "Social and Emotional Development of Students in College and University," in *Mental Hygiene*, Part II, Vol. 43, October, 1959.

In those colleges where the needs are apparent and recognized, encouraging beginnings can and are being made by the establishment of a special committee whose duty it is to study whatever influences on the campus may be harmful to optimum emotional development of students. From the standpoint of a psychiatrist this is obviously a mental health committee, but to name it as such may be undesirable. It is ordinarily made up of the dean of students, chairmen of the counseling committees, director of the health service, a chaplain, a psychologist, a sociologist, or whatever individuals may have special concern or responsibility for helping students get from college what they came for. Weekly or bimonthly meetings of such a committee, considering the current, individual and general problems facing the institution, form a most advantageous way of acquainting the key people in the institution with the nature and scope of the emotional conditions pertaining to the effective function of any college.

THE MENTAL HEALTH MOVEMENT

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Although there are several important features of the mental health movement which are notably unclear (including the definition of both "mental health" and "movement"), one indisputable fact is the date of its founding, which was in the spring of 1908 in New Haven, Connecticut, under the energetic leadership of a former mental patient, young Clifford Whittingham Beers.

Long before Beers, there had of course been dedicated pioneers who had given themselves to improving the lot of the mentally ill, but their efforts had never taken on the characteristics of a "movement." Indeed for centuries back there have been occasional voices here and there pleading for understanding of the mentally ill, and for good care and treatment. There was, however, tragically little in the way of understanding, and almost nothing that could be called treatment in the average "insane asylum" at the turn of the century when Clifford Beers, a few years out of college, experienced a mental breakdown and had to be hospitalized. His sufferings were excruciating. Long before he was ready for release, ideas about reform began to take shape in his still-excited brain, and he resolved that as a first step he would write a book describing conditions in the insane asylums of the day, and after that he would spearhead a citizens' movement to reorganize the entire system.

The book he wrote, *A Mind That Found Itself*, is one of the great autobiographies of all time. First published in 1908, and now in its thirty-fifth printing, it has inspired successive generations of students, and motivated countless citizens' groups to effort on behalf of the mentally ill.

One of the first people to recognize its worth was the distinguished Harvard psychologist, William James, who read it in manuscript form and from that moment became a staunch supporter of Clifford Beers and his movement. Others among Beers's early supporters included such outstanding physicians as William H. Welch of Johns Hopkins, and

Adolf Meyer, later known for his brilliant contributions to psychiatry and who, incidentally, recommended the term "Mental Hygiene" for the new movement.

To realize what Clifford Beers and his supporters were up against during the first decade of the 1900's, one must remember the primitiveness of facilities for the care of mental patients and of attitudes toward them. Medical education was still a sad hotchpotch of science and fiction, and psychiatry was only in its infancy. The profession of psychiatric social work had not yet been born. Mental tests were just beginning to be developed. Early clinics, both for mental patients and for children, were just coming to be established. There was no systematic reporting of hospital patients, no agreed standards for care, no consistent legislation for the protection of patients, and no place where a concerned person could go to find out the facts.

From the beginning, Clifford Beers was crystal clear about how he expected to improve matters. He intended to develop a "citizens' movement" and he proposed to enlist the top leadership of the day, both lay and professional, but especially professional. Indeed, much of the strength of the mental hygiene movement during its first decades can be traced to the consistency with which these two ideas were put into effect.

Clifford Beers envisioned a network of mental hygiene societies, eventually stretching around the world, which would be the instruments of reform. He was eager to initiate a national society but thought that the best plan would be to organize a state society first, in order to learn methods of procedure. Accordingly, on May 6, 1908, he called together a group of prominent Connecticut citizens and organized the Connecticut Society for Mental Hygiene, the first state society of its kind, and the prototype of later societies. Its charter charged it with responsibility in all the areas that continue to be the concern of mental health associations to this day: improvement of standards of care for the mentally ill; the prevention of mental disorder and mental deficiency; the conservation of mental health; and the dissemination of sound information.

Less than a year later, on February 19, 1909, Clifford Beers brought a similar group together in New York City and organized the National Committee for Mental Hygiene. From that time on until his death in 1943, Beers gave himself to the mental hygiene movement. He was a powerful persuader and highly successful in stirring up enthusiasm, but

he was willing to leave much of the actual program planning in the hands of the professionals whose leadership he mobilized.

During the first several years of the National Committee's existence, there were no funds and therefore no staff. Clifford Beers paid expenses out of his own pocket—with borrowed money. When in 1912, through the kindness of Henry Phipps, funds finally became available, the committee employed young Thomas W. Salmon, who was soon appointed first medical director and became an extremely important person in shaping the activities of the committee and of the entire movement throughout its early years.

One of the first major tasks on which Thomas Salmon embarked was a series of field trips to find out at firsthand how the mentally ill were being cared for in this country. What he found was utterly heart-breaking. Ignorance, neglect, cruelty—overcrowding, filth, cold—cages, chains, beatings, starvation. Clifford Beers 'had not exaggerated. Thomas Salmon visited not only the asylums charged with caring for the insane but the still larger number of unsuitable institutions where they were actually to be found, such as jails, almshouses, county poor farms, and old peoples' homes. Out of these visits grew a plan for hospital surveys, which soon became one of the most important activities of the National Committee and eventually grew into the Committee's Division on Hospital Services, which in turn grew into the Mental Hospital Survey Committee, sponsored by a number of state and governmental agencies, and still later became the Central Inspection Board of the American Psychiatric Association.

From the first, members of the National Committee staff felt pressed to address themselves to many problems at once. Because of the dearth of information about mental patients in institutions, they undertook to compile essential statistics but immediately ran into the problem of nomenclature on which there was at that time no uniformity whatever. This quickly brought them into cooperation with a variety of other agencies which shared some of the same interests, such as the American Medico-Psychological Association (later the American Psychiatric Association), the Public Health Service, and the Bureau of the Census. In fact, this pattern of developing cooperative relationships with other agencies and professional groups was part of the National Committee's conception of itself from the beginning. Also in several instances it stood *in loco parentis* to groups which later became extremely important in the mental health scene. For instance, the committee offered hospitality in the form of office space and often also of staff time to the

American Psychiatric Association, the American Association of Psychiatric Social Workers (now the Psychiatric Social Work Section of the National Association of Social Workers), the American Orthopsychiatric Association, and the American Association of Psychiatric Clinics for Children—all of which had their first offices in the National Committee. In addition, the committee had a hand in creating the Central Inspection Board and the American Board of Psychiatry and Neurology.

Other interests of the early National Committee included concern for the recruitment and training of psychiatrists, and later for their certification; continuing responsibility for the compilation of statistics until that task was taken over by the Bureau of the Census in the 1920's; and education of the general public and of relevant professional groups, which involved publication of a wide range of pamphlets and of a quarterly journal, *Mental Hygiene*, which was started in 1917.

Thomas Salmon and the National Committee were just hitting their stride in 1914, when World War I loomed on the horizon. With the sensitivity for which he was noted, Salmon saw further ahead than most people and was able to predict what the problems of the mentally ill in the military effort were likely to be, and to think through constructive plans for handling them. He made some cogent recommendations to the Army Surgeon General, who appointed Salmon as Chief Psychiatrist of the American Expeditionary Force.

Salmon's master plan included elimination of the mentally deficient from the service; early identification of cases of mental disorder; prompt psychiatric treatment as near the front as possible; staff psychiatrists at base hospitals and at points of embarkation and debarkation; psychiatric consultation available to medical and line officers; and military hospitals at home for continued treatment and training. Although no master plan can be expected to work perfectly in time of war, this one was good enough so that many of the men who broke down in the service received better psychiatric care than they would have had at home. Salmon's planning was also far better than that which later took place during the first half of World War II; for, strange as it seems now, by the time World War II came along many of the lessons of World War I had been forgotten; the deficiencies, resistance, and confusion of the first two years were lamentable, and only around the middle of the war, with the appointment of William C. Menninger as head of the Neuropsychiatric Consultants Division under the Army Surgeon General, did the military manage to put into practice some of the solid principles first worked out in World War I.

During the World War I period, there was much significant ferment, some of it at the front speeded up by the pressures of war, and some of it quietly developing at home in spite of the war. Medical education, following the famous (Abraham) Flexner Report in 1910, was racing ahead rapidly. Psychiatry was at last emerging from its isolation and taking its rightful place among the medical specialties. The ancillary profession of psychiatric social work was in the process of creation with the founding of the first graduate school of psychiatric social work at Smith College in 1918. Psychopathic hospitals, in contradistinction to custodial institutions, were being built to serve a variety of purposes, including short-term care, preventive therapy, training, and research. New clinic patterns were being experimented with, and new ideas were in the air, notably, the concept of psychogenesis, with its increasing emphasis on the role of mental and emotional factors rather than organic ones as causes of mental illness, and its consequent stress on the importance of environment.

With the roaring 1920's another viable "movement" sprang up—the child guidance clinic movement, which is usually regarded as part of the mental hygiene movement of the period. In 1909, William Healy in Chicago had established the Juvenile Psychopathic Institute for the psychiatric examination of young offenders—really the first child guidance clinic—and in 1917 Healy and his associate, Augusta Bronner, went to Boston to head the Judge Baker Foundation (predecessor of the present Judge Baker Guidance Center) where they created the pattern that soon was being widely adopted by child guidance clinics, wherein psychiatrists, clinical psychologists, and psychiatric social workers, singly and together, contributed their skills to the diagnosis and treatment of each case. In 1922 (the term "child guidance clinic" first came into use that year), the National Committee established a division of prevention and delinquency, which later became the Division on Community Clinics, for many years directed by George S. Stevenson, who was later the committee's medical director. The National Committee administered a five-year program of "prevention of juvenile delinquency," financed by the Commonwealth Fund through a series of demonstration child guidance clinics established in seven major cities.

Those pioneering demonstration clinics and several others, such as the notable Institute for Child Guidance in New York City, strove to delineate the fundamental principles of successful clinic practice. They quickly discovered, for instance, how essential it is to reach children early if treatment is to be successful, and the importance of

proper community facilities as well as the cooperation of other community agencies if a child guidance clinic is to endure. The number of clinics grew rapidly. By the early 1930's there were full-time child guidance clinics in twenty-seven cities, and part-time clinics in several hundred others. Many of the early clinics became important centers for the training of psychiatric personnel, and offered a degree of leadership to the mental health movement without which it would have been poor indeed.

Meanwhile the network of state and local mental hygiene societies and committees which had been part of Clifford Beers's dream was slowly spreading through the country, and also into other countries. After the organization of the Connecticut Society in 1900, the second state society was Illinois in 1909, the same year as the National Committee. In New York the State Charities Aid Association which had taken an interest in the insane from the time of its founding in 1872, had had a committee on the aftercare of the insane since 1906, which in 1910 became the Committee on Mental Hygiene of the State Charities Aid Association (now the New York State Association for Mental Health), the third of the state societies to be formally organized. From then on, a few more societies were organized each year, some of them state, some local. By the 1930's there were about fifty or so, and by the 1940's there were thought to be about two hundred, although no actual count would have been possible. The clinics stood in a friendly but loose relationship to the National Committee—actually not a formal relationship at all—and differed widely among themselves in structure, program, and effectiveness. Public apathy was still heavy and these little knots of dedicated toilers were rarely able to rouse widespread public interest, or to bring about reforms commensurate with their hopes.

One of the first signs of speedup in the momentum of the mental hygiene movement might have been observed in the 1930's, when workers in many different professions began to take keen interest in the new ideas. Much of the leadership came from the so-called "core" professions, which included psychiatrists, psychiatric social workers, and clinical psychologists—those whose professions by definition were concerned with mental illness and the mentally ill. The related professions included doctors, nurses, teachers, social workers, clergy, and law enforcement officials—those who ordinarily had no direct responsibility for the mentally ill but who inevitably met many problems of maladjustment in their work with people and who therefore had much to learn from mental hygiene. Members of the core professions were eager

to pass on their new points of view and members of the related professions were responsive. Meetings became crowded. The literature increased. Members of the core professions were in great demand for lectures, institutes, training courses, parent-teacher associations, and the like. Even among the general public there was by this time more than a little reaching out for the new knowledge when it pertained to problems of social and emotional adjustment. But with respect to responsibility for the mentally ill, apathy was still great.

It was in the 1930's that the preference for the term "mental health" first became apparent and by the 1940's "mental hygiene" was rapidly losing favor. Although it may be questioned whether this was a wise switch, the reasons for it are self-evident. Because the mental hygiene movement was originally concerned with mental illness and mentally ill people, the term mental hygiene itself came (incorrectly) to be equated with mental illness. Moreover, since mental illness is to many people an unattractive, or even a frightening subject, they felt more comfortable in concerning themselves with what they were beginning to call "positive mental health," which, they argued, was preventive and, therefore, more important. The new term, mental health, found favor rapidly and within a few years most mental hygiene societies had changed their names to mental health associations.

One of the sequels was that the movement as a whole lost a certain part of its focus and became considerably more scattered than it had been in its early days. Many argued then—and many argue now—that this broadening of scope was essential and constructive, but it is also possible to argue that some of the subsequent vicissitudes of the mental health movement are traceable to the fact that its scope is so broad as to be undefinable.

With the end of the war in the middle 1940's, many things began to happen. Psychiatrists in the armed forces had learned a great deal from their war experience, and upon their return to civilian life were eager to broaden the scope of their services. Within the psychiatric profession there was an articulate revolt against the conservatism of the American Psychiatric Association, as seen for example in the formation of the Group for the Advancement of Psychiatry (G.A.P.), a group of younger psychiatrists who strove to formulate in practical terms what they regarded as the potential contribution of psychiatry to society. A number of other series of conferences, committees, and teaching institutes, also sprang up with somewhat similar goals.

Others whose war experiences had impressed them deeply were the

conscientious objectors who had been assigned by Selective Service to Civilian Public Service and worked as attendants in mental hospitals. While still on hospital duty during the war, they had started organizing themselves with the intention of eventually mounting an intensive campaign of public information about the deplorable conditions in mental hospitals and mobilizing public opinion to bring about reform. In 1947, they formed the National Mental Health Foundation and in several instances their efforts brought about dramatic results. They planned their publicity in a way—not to smear—but to interpret the situation and give support to the public officials who were frequently helpless in the face of public indifference.

About the middle 1940's the mental health movement and the mass media of communication discovered each other. The result was a flood of words—written, spoken, and acted out—unparalleled in the history of the mental health movement. A series of press exposés swept the country, one of the earliest and most effective being Albert Deutsch's series, "The Shame of the States," beginning in 1945, and for several years used as a model by many newspapers planning reportorial surveys. Some of these exposés were directly instrumental in bringing about reorganization of state hospital systems, increased state budgets, and the creation of new and improved facilities for the mentally ill. Radio and television also discovered mental health (and it discovered them) and there were some excellent shows, which reached vastly larger audiences than had ever before been exposed to mental health propaganda. The first thoroughly sound entertainment film presented was *The Snake Pit*, and some important new educational films appeared, the first of a wave of such films to emerge within the next decade. Drama, too, made its contribution through a remarkable series of short sketches for parent education which were widely used by amateur groups everywhere. Even cartoons and comic strips were used by mental health educators as they rapidly became "mass media" conscious.

The middle 1940's also saw important new responsibilities assumed by the federal government for the first time. In 1946, the passage of the National Mental Health Act made possible the creation of the National Institute of Mental Health which came into being in 1949 as one of the Institutes of Health of the Public Health Service, then under the Federal Security Administration, now the Department of Health, Education, and Welfare. The National Institute of Mental Health concerns itself with research, both through its intramural program and through grants-in-aid, primarily to institutions; with professional

training of mental health personnel; and with the development of community mental health programs.

Also in the middle 1940's the mental health movement began to take on a more genuinely international aspect than at any time theretofore. During his strenuous organizing days, Clifford Beers had worked hard at creating an international movement with some modicum of success. As early as 1919, he had formed an International Committee for Mental Hygiene and had been instrumental in initiating mental hygiene committees in three or four countries. By the time of the first International Congress of Mental Hygiene in Washington, D.C. in 1930, there were mental hygiene societies in some twenty-five countries, but like those in the United States some existed more on paper than as active agencies, and there was little that was truly international in character in the sense of being "between" nations. In 1948, a large Third International Congress on Mental Health was held in London, during which the World Federation for Mental Health was brought into being, with John R. Rees as president and executive director. The World Federation for Mental Health holds official consultative status with several of the specialized agencies of the United Nations. Another important international agency currently active is the Mental Health Division of the World Health Organization.

Although the 1950's are still too close to permit the perspective with which it is possible to view earlier decades, certain trends are apparent. Throughout the 1950's a great deal of the energy of organized citizens' groups was devoted to publicizing the mental health movement. In 1950, the National Committee for Mental Hygiene merged with the National Mental Health Foundation and the Psychiatric Foundation to form the National Association for Mental Health. The new organization concentrated heavily on publicity and on organizing local associations, to the end that in 1960 it was able to report that some 800 state and local associations were then affiliated with it and that approximately a million volunteers were active in the mental health movement. With the national umbrella of publicity provided by the National Association, the locals stepped up their own publicity and their fund-raising drives, with the result that an amount of publicity unprecedented by comparison with earlier periods was poured forth during the decade.

Another important trend of the 1950's was the evidence of improvement in mental hospitals. Many factors entered in, such as larger state budgets, the availability of more trained personnel, increased citizen

responsibility, support from a variety of government activities, and the introduction of the tranquilizing drugs. The average length of stay of patients, both new patients and older "chronics," began to be considerably reduced in many hospitals and this was gradually reflected in the statistics. In 1956, the number of patients in mental hospitals in the United States decreased and the downward curve has continued to the present. It seems that at last the nationwide "total push" is being felt.

It is, of course, impossible in a short history such as this to do justice to the literally countless activities that ought properly to be subsumed under "mental health movement." The list of omissions in this article is long and grievous. To name a few: the 1955 Mental Health Study Act creating the Joint Commission on Mental Illness and Health and the reports it has issued; the Community Mental Health Services acts in the several states where they have been passed; the recommendations of the Council of State Governments and its influence on legislation; and the influence of the Veterans Administration with the standards of care it set after World War II; new patterns of hospital care and community responsibility for the mentally ill, along with new types of therapy; the status and hopes of current research; trends in the residential treatment of mentally ill children and in facilities for the mentally deficient; changes in attitudes toward certain problems relating to the legal protection of both the mentally ill and the public; the history of each of the core professions and their contributions to mental health, as well as the contributions of the related professions; the growth of the literature, both popular and professional; the variety of programs in mental health associations; mental health education and the controversies currently raging over "evaluation"; acknowledgment to some of the scores of capable and dedicated people who have given their lives to the field; and the long and fascinating tale of the sixty-year evolution in concepts about both mental illness and normal behavior.

A balanced assessment of the present status of the mental health movement is extraordinarily difficult. Differences in opinion are to be found ranging from extremes of rejoicing over progress to equal extremes of gloom because progress is so slow. The key word frequently turns out to be "but. . . ." We have come a long way—but—we still have a long way to go. The care of mental patients has improved—but—it is still a far cry from what it ought to be in a prosperous and humane nation. We know more about illness than any previous period in history—but—we still do not know the basic causes of psychosis. More

citizens are better informed than ever before—but—the interest of still more must be enlisted if they are to fulfill their responsibilities to their less fortunate fellows. The body of knowledge developed around mental health concepts is now reaching into many areas of endeavor heretofore untouched—but—these ideas must spread faster and farther and become more scientific if they are to help solve some of the age-old problems of human behavior.

As indicated in the opening sentences of this article, there is much about the mental health movement that is unclear, including the definition of terms. The ambiguity has long plagued the field and seems to be getting more acute as time goes on. This presents practical problems because one of the consequences of ambiguity is that people who share the same goals and ideals, too often fail to agree on how to proceed to bring them about. A major task ahead for the mental health movement is to take a hard look at itself, decide what does not belong within its purview, as well as what does, and proceed forthwith to some painful and realistic delineation of its own field.

For readers who wish to pursue the history of the mental health movement, there is a handful of particularly relevant books. *A Mind That Found Itself* by Clifford Beers sets the stage for all that came later—and incidentally each edition since the first (1908) has included valuable historical appendices describing the mental health movement to date. Albert Deutsch's dramatic and scholarly *The Mentally Ill in America* is a superb account of attitudes toward the mentally ill and activities in their behalf from the earliest days in this country up through the middle 1930's. Earl D. Bond's *Thomas W. Salmon: Psychiatrist* is a lively record of the early days of the National Committee for Mental Hygiene and its brilliant and sensitive first director, who did so much to shape the movement. Nina Ridenour's *Mental Health in the United States: A Fifty-Year History*, with an introduction by William C. Menninger, is a concise summary of the mental health movement from its founding up to 1960.

Other significant histories are *Child Guidance Clinics: A Quarter Century of Development* by George S. Stevenson and Geddes Smith; *One Hundred Years of American Psychiatry (A.P.A.)*; and *Orthopsychiatry 1923–1948: Retrospect and Prospect*, edited by Lawson G. Lowrey.

Particularly relevant aspects of the current status of the mental health movement are treated in a series of reports on the findings of the Joint Commission on Mental Illness and Health, created by Congress

under a Mental Health Study Act in 1955. Each volume is by a different author or authors. The subjects include concepts of positive mental health, the economics of mental illness, manpower trends, sampling survey of mental health, the role of schools, research resources, religion and mental health, community resources, epidemiology of mental illness, and the care of mental patients.